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

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December 2009
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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 website at **http://www.medicarenhic.com/dme/**

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CENTERS for MEDICARE & MEDICAID SERVICES

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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.

Legend

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

2010 Annual Update of HCPCS Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) for the Common Working File (CWF), A/B MACs, Medicare Carriers and Fiscal Intermediaries (FIs) (GEN)

MLN Matters® Number: MM6619
Related CR Release Date: September 4, 2009
Related CR Transmittal #: R1814CP
Related Change Request (CR) #: 6619
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or 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
This article is based on Change Request (CR) 6619 which provides the 2010 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) that will be used in Medicare claims processing systems. Be sure billing staff are aware of these updates.

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. These edits only allow services that are excluded from SNF CB to be separately paid by Medicare contractors. The related policy is contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6) which is available at **http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Physicians and providers are advised that, by the first week in December 2009, new code files will be posted at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS Web site.

Institutional providers should 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.

Additional Information
You can find information related to SNFs and Medicare on the CMS Skilled Nursing Facility Center at **http://www.cms.hhs.gov/center/snf.asp** on the CMS Web site.

The official instruction, CR 6619, 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/R1814CP.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 HCPCS Codes Used for Home Health (HH) Consolidated Billing Enforcement (GEN)

MLN Matters® Number: MM6662
Related CR Release Date: October 9, 2009
Related CR Transmittal #: R1827CP

Related Change Request (CR) #: 6662
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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
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). Make sure your billing staff is aware of these changes.

What You Need to Know
CR6662 provides the annual HH consolidated billing update effective January 1, 2010.

The following two HCPCS codes are added to the home health consolidated billing supply code list. Code A4456 is a new code that replaces code A4365 which is deleted below.

Added HCPCS Code	Descriptor
A4360	Disposable external urethral clamp or compression device with pad and/or pouch
A4456	Ostomy adhesive remover wipe

The following HCPCS code is deleted from the home health consolidated billing supply code list.

Deleted HCPCS Code	Descriptor
A4365	Ostomy adhesive remover wipe

Background
The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the HH PPS. With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH 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 (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Additional Information
If you have questions, please contact your Medicare carrier/FI/RHHI/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 official instruction (CR6662) issued to your Medicare carrier/FI/RHHI/MAC is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1827CP.pdf** on the CMS Web site.

Calendar Year (CY) 2010 Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (GEN)

MLN Matters® Number: MM6720
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R1853CP

Related Change Request (CR) #: 6720
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed
This article, based on CR 6720, advises you of the CY 2010 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the Background section below. Please note that the fee schedule for Code E2227 (Manual Wheelchair Accessory, Gear Reduction Drive Wheel, Each) is being revised, effective January 1, 2010, to remove pricing information for one product that was used in calculating payment for E2227. That product was erroneously classified as a gear reduction drive wheel when the code was established. Providers should be aware that your Medicare contractor will not adjust previously processed claims for the code E2227 with dates of service on or after January 1, 2009 through December 31, 2009, if they are submitted for adjustments. These changes are effective for DMEPOS provided on or after January 1, 2010. Be sure your billing staffs are aware of these changes.

Background
CR 6720 provides instructions regarding the 2010 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by sections 1834(a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) section 414.102 for parenteral and enteral nutrition (PEN).

Key Points of CR 6720
The DMEPOS fee schedule file will be available on or after November 17, 2009, for State Medicaid Agencies, managed care organizations, and other interested parties at **http://www.cms.hhs.gov/DMEPOSFeeSched/** on the CMS Web site.

2010 Fees for HCPCS labor payment codes K0739, L4205, L7520 are effective January 1, 2010, and those rates are as follows:

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
AK	25.27	28.79	33.88		NC	13.41	19.99	27.14
AL	13.41	19.99	27.14		ND	16.72	28.73	33.88
AR	13.41	19.99	27.14		NE	13.41	19.97	37.84
AZ	16.59	19.97	33.39		NH	14.40	19.97	27.14
CA	20.58	32.83	38.26		NJ	18.10	19.97	27.14
CO	13.41	19.99	27.14		NM	13.41	19.99	27.14
CT	22.40	20.45	27.14		NV	21.37	19.97	36.99
DC	13.41	19.97	27.14		NY	24.71	19.99	27.14
DE	24.71	19.97	27.14		OH	13.41	19.97	27.14
FL	13.41	19.99	27.14		OK	13.41	19.99	27.14
GA	13.41	19.99	27.14		OR	13.41	19.97	39.03
HI	16.59	28.79	33.88		PA	14.40	20.56	27.14
IA	13.41	19.97	32.49		PR	13.41	19.99	27.14
ID	13.41	19.97	27.14		RI	15.99	20.58	27.14

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
IL	13.41	19.97	27.14		**SC**	13.41	19.99	27.14
IN	13.41	19.97	27.14		**SD**	14.99	19.97	36.28
KS	13.41	19.97	33.88		**TN**	13.41	19.99	27.14
KY	13.41	25.60	34.71		**TX**	13.41	19.99	27.14
LA	13.41	19.99	27.14		**UT**	13.45	19.97	42.27
MA	22.40	19.97	27.14		**VA**	13.41	19.97	27.14
MD	13.41	19.97	27.14		**VI**	13.41	19.99	27.14
ME	22.40	19.97	27.14		**VT**	14.40	19.97	27.14
MI	13.41	19.97	27.14		**WA**	21.37	29.30	34.80
MN	13.41	19.97	27.14		**WI**	13.41	19.97	27.14
MO	13.41	19.97	27.14		**WV**	13.41	19.97	27.14
MS	13.41	19.99	27.14		**WY**	18.70	26.65	37.84
MT	13.41	19.97	33.88					

The following new codes are effective as of January 1, 2010:

- A4264, A4466, L2861, L3891, L8692, K0739, and K0740, all of which have no assigned payment category;
- A4336, A4360, and A4456, which are in the ostomy, traheostomy, and urological supplies payment category;
- E0433 in the oxygen and oxygen equipment category;
- E0136 in the capped rental category; and
- L5973, L8031, L8032, L8627, L8628, L8629, and Q0506, all of which are in the prosthetics and orthotics category.

The fee schedule amounts for the above new codes will be established as part of the July 2010 DMEPOS Fee Schedule Update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2010 through June 30, 2010. **The new codes are not to be used for billing purposes until they are effective on January 1, 2010.**

The following codes are being deleted from the HCPCS effective January 1, 2010, and are therefore being removed from the DMEPOS fee schedule files:

A4365	L1825	L3701
E2223	L1901	L3909
E2393	L2770	L3911
L0210	L3651	L6639
L1800	L3652	
L1815	L3700	

For gap-filling purposes, the 2009 deflation factors by payment category are listed as follows:

Factor	Category
0.508	Oxygen
0.511	Capped Rental
0.512	Prosthetics and Orthotics
0.650	Surgical Dressings
0.707	Parenteral and Enteral Nutrition

Code E2227 *Manual Wheelchair Accessory, Gear Reduction Drive Wheel, Each* was added to the HCPCS effective January 1, 2008. The fee schedule for code E2227 was calculated using pricing information for two products; however, the fee schedule is being revised effective January 1, 2010, to remove pricing information for one product that was erroneously classified as a gear reduction drive wheel when the code was established. Contractors will not adjust previously processed claims for the code E2227 with dates of service on or after January 1, 2009 through December 31, 2009, if they are submitted for adjustments.

CY 2010 Fee Schedule Update Factor

Under the Act, the DMEPOS fee schedule amounts are being updated for 2010 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2009. Since the percentage

change in the CPI-U for the 12-month period ending with June of 2009 is negative (-1.41 percent), the percentage increase in the CPI-U used to update the DMEPOS fee schedule amounts for 2010 is **0 percent**.

2010 Update to the Labor Payment Rates
Since the percentage increase in the Consumer Price Index (CPI) for the 12 month period ending with June of the previous year is negative for 2010, a 0% change is applied to the labor payment amounts for 2010 for codes K0739, L4205, and L7520.

2010 National Monthly Payment Amounts for Stationary Oxygen Equipment
CMS will also implement the 2010 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, 2010.

The fee schedule file is being revised to include the new national 2010 monthly payment rate of $173.17 for stationary oxygen equipment. The payment rates are being adjusted for the new oxygen generating portable equipment (OGPE) class. The revised 2010 monthly payment rate of $173.17 includes the 0% update due to the -1.41% CPI-U change. The budget neutrality adjustment for 2010 caused the 2010 rate to decrease from $175.79 to $173.17.

When updating the oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS code E1405 and E1406 for oxygen and water vapor enriching systems. 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.

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.

The official instruction, CR 6720, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1853CP.pdf** on the CMS Web site. CR 6720 includes the revisions that will be made to the *Medicare Claims Processing Manual*, Chapter 23 - Fee Schedule Administration and Coding Requirements.

More information on Durable Medical Equipment Prosthetics, Orthotics, and Supplies is available at **http://www.cms.hhs.gov/center/dme.asp** on the CMS Web site.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (GEN)

MLN Matters® Number: MM6604
Related CR Release Date: August 28, 2009
Related CR Transmittal #: R1804CP
Related Change Request (CR) #: 6604
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

Provider Action Needed
CR 6604, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2009. Be sure billing staff are aware of these changes.

Background
For Medicare, the reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by

any health care organization. The RARC list is updated 3 times a year - in early March, July, and November although the Committee meets every month.

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are posted at **http://www.wpc-edi.com/Codes** on the Internet. The lists following the end of the "Additional Information" section of this article summarize the latest changes to these lists, as announced in CR 6604.

Additional Information
To see the official instruction (CR6604) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1804CP.pdf** on the CMS Web site.

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

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or 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.

New Codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	1/1/2010

Modified Codes - CARC

Code	Current Narrative	Effective Date (per WPC posting)
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 04/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. This change to be effective 04/01/2010: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
54	Multiple physicians/assistants are not covered in this case. This change to be effective 04/01/2010: Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010

Code	Current Narrative	Effective Date (per WPC posting)
55	Procedure/treatment is deemed experimental/investigational by the payer. This change to be effective 04/01/2010: Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. This change to be effective 04/01/2010: Procedure/treatment has not been deemed `proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. This change to be effective 04/01/2010: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 04/01/2010: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment, if present.	4/1/2010
90	Ingredient cost adjustment. This change to be effective 04/01/2010: Ingredient cost adjustment. Note: To be used for pharmaceuticals only.	4/1/2010

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
156 *	Flexible spending account payments. Note: Use code 187.	10/1/2009

- Also included in CR 6453

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N519	Invalid combination of HCPCS modifiers.	NO
N520	Alert: Payment made from a Consumer Spending Account.	NO

Modified Codes - RARC:
None

Deactivated Codes - RARC
None

Claim Status Category Code and Claim Status Code Update (GEN)

MLN Matters® Number: MM6723
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R1852CP

Related Change Request (CR) #: 6723
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected
All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed
This article, based on CR6723, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the September 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on the Internet on November 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the September 2009 committee meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on November 1, 2009. Medicare will implement those changes on January 4, 2010 as a result of CR6723.

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 Centers for Medicare & Medicaid Services (CMS) Web site.

The official instruction issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1852CP.pdf** on the CMS Web site.

Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody under a Penal Authority and Examples of Application of Government Entity Exclusion (GEN)

MLN Matters® Number: MM6544 - Revised
Related CR Release Date: September 4, 2009
Related CR Transmittal #: R1812CP and R110BP

Related Change Request (CR) #: 6544
Effective Date: December 7, 2009
Implementation Date: December 7, 2009

Note: *This article was revised on September 14, 2009, to add DME MACs in the "Provider Affected" section. DME MACs may also receive claims and are included in Change Request 6544. All other information remains unchanged.*

Provider Types Affected
This article is for 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 individuals or groups of individuals who are in "custody" under a penal statute or rule.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 6544, which describes special conditions that must be met in order for Medicare to make payment for services provided to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute or rule.

What You Need to Know
CR 6544 instructs Medicare contractors that "payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and the State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

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

Background
Under the Social Security Act (Section 1862(a)(2); see **http://www.ssa.gov/OP_Home/ssact/title18/1862.htm** on the Internet), the Medicare program does not pay for services if:

- The beneficiary has no legal obligation to pay for the services, and
- No other person or organization has a legal obligation to provide or pay for that service.

In addition, under the Social Security Act (Section 1862(a)(3)), if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services.

In the Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule published in the Federal Register, Volume 72, Number 162 (72 FR 47409 and 47410 - August 22, 2007; see **http://edocket.access.gpo.gov/2007/07-3820.htm** on the Internet), the Centers for Medicare & Medicaid Services (CMS) clarified the regulations at 42 CFR Section 411.4(b) (See **http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr411.4.htm** on the Internet) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are:

- Under arrest;
- Incarcerated;
- Imprisoned;
- Escaped from confinement;
- Under supervised release;
- On medical furlough;
- Required to reside in mental health facilities;
- Required to reside in halfway houses;
- Required to live under home detention; or
- Confined completely or partially in any way under a penal statute or rule.

The *Medicare Claims Processing Manual*, Chapter 1, Section 10.4 describes the **special conditions that must be met** in order for Medicare to make payment for individuals who are in custody as follows:

> "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:
>
> 1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and

2. The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Providers and suppliers are reminded that if they render services or items to a prisoner or patient in a jurisdiction that meets these conditions of 42 CFR 411.4(b), they are to include modifier QJ on claims submitted to carriers, A/B MACs, or DME MACs or use condition code 63 on institutional claims sent to Medicare FIs or A/B MACs.

Change Request (CR) 6544 also amends the *Medicare Benefit Policy Manual* (Chapter 16, Section 50.3.3) and the *Medicare Claims Processing Manual* (Chapter 1, Section 10.4) in order to be consistent with 42 CFR Section 411.4(b). These revisions are included as attachments to CR 6544.

Additional Information
There are two transmittals associated with the official instruction, CR 6544, issued to your carrier, FI, and A/B MAC regarding this change. The first transmittal amends the *Medicare Claims Processing Manual* and it may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1812CP.pdf** on the CMS Web site. The second transmittal amends the *Medicare Benefit Policy Manual* and it may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R110BP.pdf** on the CMS Web site.

If you have any questions, please contact your 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.

Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (OXY)

MLN Matters® Number: MM6716
Related CR Release Date: November 2, 2009
Related CR Transmittal #: R589OTN
Related Change Request (CR) #: 6716
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected
This article is for suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs) and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for oxygen services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on change request (CR) 6716, which provides instructions on continuing the payment policy for general maintenance and servicing of certain oxygen equipment after the 36-month rental cap, as established in calendar year (CY) 2009, for dates of service through June 30, 2010. See the *Key Points* section of this article for specific payment instructions.

Background
Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36 month rental cap. Section 144(b)(1) of the MIPPA, provides for payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap if the Secretary of the Department of Health and Human Services determines that such payments are reasonable and necessary. Initial instructions relating to the maintenance and servicing payments for oxygen concentrators and transfilling equipment for CY 2009 were issued in Transmittal 497, CR 6509, dated May 22, 2009. The MLN Matters® article for this CR is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6509.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site. CR6716 provides instructions on the continuation of these maintenance and servicing payments in CY 2010 for dates of service through June 30, 2010.

As indicated in Transmittal 497 (CR 6509), CMS determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under Healthcare Common

Procedure Coding System (HCPCS) codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made no more often than every 6 months, beginning 6 months after the 36-month rental cap (as early as July 1, 2009, in some cases). In CY 2009, the allowed payment amount for each visit is equal to the 2009 fee for code K0739, multiplied by 2, for the State in which the in-home visit takes place. Suppliers should use the HCPCS code for the equipment E1390, E1391, E1392 and/or K0738 along with the MS modifier in order to bill and receive payment for these maintenance and servicing visits.

For example, if the supplier visits a beneficiary's home in Pennsylvania to perform the general maintenance and servicing on a portable concentrator, the supplier would enter E1392 MS on the claim and the allowed payment amount would be equal to the lesser of the supplier's actual charge or two units of the allowed payment amount for K0739 in Pennsylvania. If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a stationary concentrator (E1390 or E1391) and a transfilling unit (K0738), payment can be made for maintenance and servicing of both units (E1390MS or E1391MS, and K0738MS). If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a portable concentrator (E1392), payment can only be made for maintenance and servicing of the one unit/HCPCS code (E1392MS).

For example, if maintenance and servicing is billed for a column I code, additional payment for the maintenance and servicing of any of the column II codes will not be made.

Column I	Column II
E1390 MS	E1391 MS, E1392 MS
E1391 MS	E1390 MS, E1392 MS
E1392 MS	E1390 MS, E1391 MS, K0738 MS
K0738 MS	E1392 MS

For CY 2010, CMS has determined that it is reasonable and necessary to continue the existing payments and payment methodology, as described above and in Transmittal 497 (CR 6509), for maintenance and servicing of certain oxygen equipment for dates of service through June 30, 2010. For dates of service from January 1, 2010 through June 30, 2010, the allowed payment amount for each visit is equal to 2 units of the 2010 fee for code K0739, for the State in which the in-home visit takes place.

Key Points of CR 6716

- Medicare contractors will pay claims with dates of service from July 1, 2009 thru June 30, 2010, for maintenance and servicing for oxygen concentrators no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use when billed with one of the following HCPCS codes and modifiers:
    - E1390MS;
    - E1391MS; or
    - E1392MS.

- In addition to payment for maintenance and servicing for stationary oxygen concentrators (HCPCS codes E1390 or E1391 Medicare contractors will pay claims with dates of service from July 1, 2009 through June 30, 2010, for maintenance and servicing for portable oxygen transfilling equipment (HCPCS code K0738) no more often than every 6 months beginning 6 months after the end of the 36th month of continuous use when billed with the HCPCS modifier MS.

- Medicare contractors will not pay for maintenance and servicing of both a portable oxygen concentrator (E1392MS) and portable oxygen transfilling equipment (K0738MS).

- For the oxygen equipment codes E1390, E1391, E1392, and K0738, billed with the modifier "MS", Medicare contractors will make maintenance and servicing payments for covered services equal to the lesser of the supplier's actual charge or 2 units of K0739 every 6 months.

- Medicare contractors will deny claims for maintenance and servicing of oxygen equipment when billed with the HCPCS codes E0424, E0439, E0431, E0434, E1405 or E1406 and the "MS" modifier.

Additional Information
If you have questions, please contact your Medicare 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 official instruction, CR6717, issued to your RHHI, MAC, DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R589OTN.pdf** on the CMS Web site.

January 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (GEN)

MLN Matters® Number: MM6708
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R1854CP
Related Change Request (CR) #: 6708
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected
All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (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.

Provider Action Needed
This article is based on Change Request (CR) 6708, which instructs Medicare contractors to download and implement the January 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2009, July 2009, April 2009, and January 2009 files. Medicare will use the January 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 4, 2010, with dates of service January 1, 2010, through March 31, 2010. See the Background and Additional Information Sections of this article for further details regarding these changes.

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 ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. Note that payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) under a separate CR.

The following table shows how the quarterly payment files will be applied (for those files that are released):

Files	Effective Dates of Service
January 2010 ASP and NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC files	January 1, 2009, through March 31, 2009

Additional Information
If you have questions, please contact your Medicare MAC, carrier, or FI 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 (CR6708) issued to your Medicare MAC, carrier, and/or FI may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1854CP.pdf** on the CMS Web site.

Medicare Fee-for-Services (MFFS) Billing for the Administration of the Influenza A (H1N1) Virus Vaccine (DRU)

MLN Matters® Number: SE0920 - 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 September 10, 2009.The title of the article was changed and there were references to two MLN Matters® articles (MM6626 and MM6617) added to the Additional Information section. All other information remains the same.*

Provider Types Affected
Physicians, providers, and suppliers administering the H1N1 vaccine to Medicare patients are affected by this article.

Provider Action Needed
This article explains Medicare coverage and reimbursement rules for the H1N1 vaccine. All providers administering this vaccine should review this article and be sure that their billing staffs are aware of this information.

Background
Medicare Part B provides coverage for the seasonal influenza virus vaccine and its administration as part of its preventive immunization services. The Part B deductible and coinsurance do not apply for the seasonal influenza virus vaccine and its administration. Typically, the seasonal influenza vaccine is administered once a year in the fall or winter. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when deemed to be a medical necessity. The Influenza A (H1N1) virus has been identified as an additional type of influenza. The H1N1 virus vaccine will be provided to Medicare Part B beneficiaries as an additional preventive immunization service. Medicare will pay for the **administration** of the H1N1 vaccine.

The Centers for Medicare & Medicaid Services (CMS) has created two new HCPCS codes for H1N1, effective for dates of service on and after September 1, 2009:

- G9141 - Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)
- G9142 - Influenza A (H1N1) vaccine, any route of administration

Payment for G9141 (Influenza A (H1N1) immunization administration, will be paid at the same rate established for G0008 (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis V04.81 (influenza), and, depending on the provider type, using revenue code 771. The same billing rules apply to the H1N1 virus vaccine as the seasonal influenza virus vaccine with one exception. Since the H1N1 vaccine will be made available **at no cost to providers**, Medicare will not pay providers for the vaccine. Providers do not need to place the G9142 (HIN1 vaccine code) on the claim. However, if the G9142 appears on the claim, only the claim line will be denied.

Payment will not be made to providers for office visits when the only purpose of the visit is to administer either the seasonal and/or the H1N1 vaccine(s).

Providers who normally participate in the Medicare Part B program as mass immunizer roster billers and mass immunizer centralized billers may submit H1N1 administration claims using the roster billing format. The same information must be captured for the H1N1 roster claims as it is for the seasonal influenza roster claims. The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;

- Control number for Medicare contractor;
- Patient's health insurance claim number;
- Patient's name;
- Patient's address;
- Date of birth;
- Patient's sex; and
- Beneficiary's signature or stamped "signature on file".

For this upcoming flu season, Medicare will reimburse Medicare beneficiaries, up to the fee schedule amount, for the administration of H1N1 influenza vaccine when furnished by a provider not enrolled in Medicare. Beneficiaries must submit a Form CMS-1490S to their local Medicare contractor. Medicare will reimburse beneficiaries for the administration of the H1N1 vaccine, but not the H1N1 vaccine itself because the H1N1 vaccine will be furnished at no cost to all providers. Medicare beneficiaries may not be charged any amount for the H1N1 vaccine itself.

Finally, Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. We understand that such preparations are critical for the upcoming flu season, especially in planning for the influenza A [H1N1] vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination per year is medically necessary (i.e. the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Our Medicare claims processing contractors have been notified to expect and prepare for earlier-than-usual seasonal flu claims and there should not be a problem in getting those claims paid. Furthermore, in the event that it is necessary for Medicare beneficiaries to receive both a seasonal flu vaccination and an influenza A [H1N1] vaccination, then Medicare will pay for both. However, as noted earlier, please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

Additional Information

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

You may also want to review the following *MLN Matters*® articles:

- MM6626 (*October 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)*) at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6626.pdf**; and

- MM6617 (*October Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)*) at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6617.pdf** on the CMS Web site.

Reasonable Charge Update for 2010 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses (SPE)

MLN Matters® Number: MM6691
Related CR Release Date: October 23, 2009
Related CR Transmittal #: R1834CP

Related Change Request (CR) #: 6691
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected

Physicians, providers, and suppliers, billing Medicare contractors (Carriers, Fiscal Intermediaries, (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses, should be aware of this article.

Provider Action Needed

The 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.

CR6691, 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 2010. Make sure your billing staff are aware of these changes.

Background
CR6691 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 2010.

The inflation indexed charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the consumer price index for all urban consumers (CPI-U)(United States city average) for the 12-month period ending with June of 2009.

Since the percentage change in the CPI-U for the 12-month period ending with June of 2009 is negative (-1.41 percent), the IIC update factor for 2010 is 0 percent. The 2010 payment limits for splints and casts will be based on the 2009 limits that were announced in CR 6221 last year. Those limits are repeated in Attachment A at the end of this article. 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) The Q-codes should be used 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. An attachment to CR6691 lists the 2010 Payment Limits for Splints and Casts.

CR6691 instructs your carrier or MAC to: 1) Compute 2010 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, 2008, through June 30, 2009; and 2) Compute 2010 IIC amounts for these codes that were not paid using gap-filled payment amounts in 2009.

For codes identified in the following four tables, CR6691 instructs DME MACs to compute 2010 customary and prevailing charges using actual charge data from July 1, 2008 through June 30, 2009; and to compute 2010 IIC amounts for these codes that were not paid using gap-filled amounts in 2009.

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			

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 Centers for Medicare & Medicaid Services (CMS) Web site.

For complete details regarding this Change Request (CR) please see the official instruction (CR 6691) 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/R1834CP.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

Code	Payment Limit	Code	Payment Limit
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

Therapy Cap Values for Calendar Year (CY) 2010 (SPE)

MLN Matters® Number: MM6660 - Revised
Related CR Release Date: November 23, 2009
Related CR Transmittal #: R1860CP
Related Change Request (CR) #: 6660
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Note: *This article was revised on November 24, 2009, to reflect a revised CR 6660 that the Centers for Medicare & Medicaid Services issued on November 23, 2009. As a result of the revised CR, the article was revised to include Regional Home Health Intermediaries as an additional contractor type involved with this issue. The CR release date, transmittal number, and Web address for accessing CR 6660 were also changed. Also, carriers were added as a contractor type involved as they were inadvertently not included in the original article. All other information remains the same.*

Provider Types Affected
This article is for providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (A/B MACs), and/or DME Medicare Administrative Contractors (DME MACs)) for physical therapy, speech-language pathology, and/or occupational therapy services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6660 which describes the policy for outpatient therapy caps for 2010 and announces that therapy caps for 2010 will be $1860. Billing staff should be aware of these revised caps.

Background
The Balanced Budget Act 1997, P.L. 105-33, Section 4541(c) set annual caps for Part B Medicare patients. These limits change annually. The Deficit Reduction Act of 2005 (signed Feb. 8, 2006) directed that a process for exceptions to therapy caps for medically necessary services be implemented. Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008, and Section 141 extended the effective date of the exceptions process to the therapy caps to December 31, 2009. The exceptions process will continue unchanged for the time frame directed by Congress.

For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1860 for calendar year (CY) 2010. For occupational therapy services, the limit is $1860 for CY 2010. The limit is based on incurred expenses and includes applicable deductible and coinsurance.

CR 6660 revises the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10 (Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General), and Section 20 (HCPCS Coding Requirement) to include the CY 2010 therapy caps, and this revision is included as an attachment to CR 6660.

Additional Information
You can find out more about Medicare therapy services and resources at **http://www.cms.hhs.gov/therapyservices/** on the Centers for Medicare and Medicaid Services (CMS) Web site.

The official instruction, CR 6660, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1860CP.pdf** on the CMS Web site.

Fee Schedule Updates (GEN)

The 2009 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**. This quarter the following notices have been posted:

- **There are no updates to the 4th Quarter 2009 Jurisdiction A DME MAC Fee Schedule**
- 4th Quarter 2009 Oral Anticancer Drug Fees
- 4th Quarter 2009 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2009 Average Sales Price Medicare Part B Drug Pricing File - Revised 10-01-2009
- 2nd Quarter 2009 Average Sales Price Medicare Part B Drug Pricing File - Revised 10-01-2009

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.

A "*VPIQ User Guide to the CMN*" is now available to assist with understanding the CMN/DIF screen information at:
http://www.medicarenhic.com/dme/edi/VPIQ_CMN_User_Guide.pdf

2009 - 2010 Seasonal Influenza (Flu) Resources for Health Care Professionals (GEN)

MLN Matters® Number: SE0926 - 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 7, 2009, to include a link on page 3 to MLN Matters® article number MM6608, which includes the payment allowances for the 2009-2010 influenza vaccine. All other information remains the same.*

Provider Types Affected
All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for seasonal 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 2009 - 2010 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- **Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.**
- **Don't forget to immunize yourself and your staff.**

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 seasonal flu vaccines and their administration. (*Medicare provides coverage of the seasonal 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 seasonal 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 seasonal 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, this year, due to planning for H1N1 flu, Medicare will make payment for seasonal flu vaccines that are provided earlier in the year than usual.

Seasonal flu vaccines can still help protect Medicare beneficiaries who get the vaccine 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 seasonal 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.

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 seasonal flu vaccines and their administration.

1. **MLN Matters® Seasonal Influenza Articles**
   - **MM6608:** Influenza Vaccine Payment Allowances - Annual Update for 2009-2010 Season at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6608.pdf** on the CMS Web site.

- **MM6539:** 2009 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6539.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 Seasonal 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 seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. This product is 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, Third 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 seasonal 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. The guide is 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. This brochure is available as a downloadable PDF file at **http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf** on the CMS Web site.

- *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 seasonal influenza, pneumococcal, and hepatitis B vaccines. This chart is 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 seasonal 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. This bookmark is 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 seasonal 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**) 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 seasonal flu vaccine awareness and utilization during the 2009 - 2010 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**;
  - **Flu.gov - http://www.flu.gov**;
  - **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/**;
  - **National Alliance for Hispanic Health - http://www.hispanichealth.org**;
  - **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.

Important information about H1N1:
Medicare will cover immunizations for H1N1 influenza, also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. H1N1 influenza vaccine is currently under production and will be available in the Fall of 2009. For more information, go to **http://www.cms.hhs.gov/H1N1** on the CMS Web site.

Activation of New Coordination of Benefits Agreement (COBA) Trading Partner Dispute Error Code Within the National Crossover Process (GEN)

MLN Matters® Number: MM6640
Related CR Release Date: September 25, 2009
Related CR Transmittal #: R562OTN

Related Change Request (CR) #: 6640
Effective Date: October 26, 2009
Implementation Date: October 26, 2009

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), 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) 6640, which conveys a new COBA trading partner dispute error code that the Coordination of Benefits Contractor (COBC) will return to Medicare contractors when certain claims are not accepted by supplemental payers. Billing staff should be aware of this change.

Background
The Coordination of Benefits Contractor (COBC) consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) developed and further refined the COBC Detailed Error Report process through the issuance of Change Request 3709 (See Transmittals 474, dated February 11, 2005, at **http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf** on the CMS Web site) and CR 5472 (See Transmittal 1189 dated February 28, 2007, at **http://www.cms.hhs.gov/Transmittals/Downloads/R1189CP.pdf** on the CMS Web site).

Under the COBC Detailed Error Report process, the COBC reports to Medicare contractors, via a standard Detailed Error Report layout, any of the following error conditions that resulted in their claims not being crossed over:

- Incoming flat file contained structural problems ("111" flat file errors);
- Incoming flat file contained claims with Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) compliance errors ("222" errors); and
- The COBA trading partner rejected the contractors' claims ("333" trading partner dispute errors).

NOTE: *Crossover is the transfer of processed claim data from Medicare operations to commercial insurance companies that sell supplemental insurance benefits to Medicare beneficiaries and to Medicaid (or state) agencies.*

Depending upon the error percentage encountered in association with errored claims, Medicare contractors then, after five (5) business days, automatically generate special provider notification letters informing the affected physician/supplier/provider that the beneficiary's claim(s) cannot be crossed over.

In earlier instructions CMS directed Medicare contractors to suppress creation of their standard provider notification letters when they receive any of the following "333" dispute reason codes via the COBC Detailed Error Reports:

- 00100 - duplicate claim;
- 000110 - duplicate claim within the same ISA-IEA loop; and
- 000120 - duplicate claim within the same ST-SE loop.

CMS made this decision primarily for two reasons:

- It was believed that these particular error conditions were out of the control of the billing provider; and

- It would be futile for the provider to bill the claims to the COBA trading partner outside the crossover process given that the entity had already received the claim, as witnessed by its lodging of a dispute on the basis of duplicate claim receipt.

Currently, the only in-use "333" dispute codes that will trigger provider notification letters are the following:

- 000200 - Claim for provider ID/state should have been excluded; 000300 - beneficiary not on eligibility-file;
- 000500 - Incorrect claim count; 000600 - claim does not meet selection criteria;
- 000700 - HIPAA Error; and
- 009999 - Other.

Through CR 6640, the COBC will activate dispute reason code 000400 (previously reserved for future use) as a new "333" trading partner dispute code. As a result of this action, the COBC will:

- Transmit error code 000400 to Medicare contractor when indicated via the COBC Detailed Error Report; and
- Include within the error description field on the COBC Detailed Error Report the following standard message: "No provider agreement with Medicaid/other payer; claims crossover not possible."

Also, as a result of CR6640, all Medicare contractors will generate error code 000400 when received via their COBC Detailed Error Report with accompanying error message on their outgoing notification letters to providers, physicians, or suppliers. As indicated in CR 6640, upon receipt of the contractor-generated special letters, affected providers, physicians, or suppliers may wish to contact their patient's indicated supplemental payer to determine next steps.

Additional Information
The official instruction, CR 6640, 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/R562OTN.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.

Delay in Implementing Phase 2 of CRs 6417 and 6421 (CMS Message 200911-35) (GEN)

The Centers for Medicare & Medicaid Services (CMS) will delay, until April 5, 2010, the implementation of Phase 2 of Change Request (CR) 6417 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)) and CR 6421 (Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). CRs 6417 and 6421 are applicable to Part B claims only.

The delay in implementing Phase 2 of these CRs will give physicians and non-physician practitioners who order items or services for Medicare beneficiaries or who refer Medicare beneficiaries to other Medicare providers or suppliers sufficient time to enroll in Medicare or take the action necessary to establish a current enrollment record in Medicare prior to Phase 2 implementation.

Although enrolled in Medicare, many physicians and non-physician practitioners who are eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare. A current enrollment record is one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and also contains the physician/non-physician practitioner's National Provider Identifier (NPI). Under Phase 2 of the above referenced CRs, a physician or non-physician practitioner who orders or refers and who does not have a current enrollment record that contains the NPI will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected.

CMS continues to urge physicians and non-physician practitioners who are enrolled in Medicare but who have not updated their Medicare enrollment record since November 2003 to update their enrollment record now. If these physicians and non-physician practitioners have no changes to their enrollment data, they need to submit an initial enrollment application which will establish a current enrollment record in PECOS.

For physicians and non-physician practitioners who order or refer-

- If you are not enrolled in the Medicare program, or if you enrolled more than 6 years ago and have not submitted any updates or changes to your enrollment information in more than 6 years, you do not have an enrollment record in PECOS. In order to continue to order or refer items or services for Medicare beneficiaries, you will have to submit an initial enrollment application. You may do so either by (1) using Internet-based PECOS (which transmits your enrollment application to the Medicare carrier or A/B MAC via the Internet - be sure to mail the signed and dated Certification Statement to the carrier or A/B MAC immediately after submitting the application), or (2) filling out the appropriate paper Medicare provider enrollment application(s) (CMS-855I and CMS-855R, if appropriate) and mailing the application, along with any required additional supplemental documentation, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application. Information on how to enroll in Medicare is found on the Medicare provider/supplier enrollment web site at **http://www.cms.hhs.gov/MedicareProviderSupEnroll**.

- If you are already enrolled in Medicare, make sure you have a current enrollment record. You can find out if you have an enrollment record in PECOS by calling your designated carrier or A/B MAC or by going on-line, using Internet-based PECOS, to view your enrollment record. We will be posting information to the Medicare provider/supplier enrollment web site that will guide you through this process. Information about Internet-based PECOS and a link to Internet-based PECOS can be found on the Medicare provider/supplier enrollment web site. Before using Internet-based PECOS, we recommend that you read the information that is posted there and that is available in the downloadable documents section.

- If you are a dentist or a physician with a specialty such as a pediatrics who is eligible to order or refer items or services for Medicare beneficiaries but have not enrolled in Medicare because the services you provide are not covered by Medicare or you treat few Medicare beneficiaries, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.

- If you are a physician who is employed by the Department of Veterans Affairs, the Public Health Service, or the Department of Defense Tricare program but have not enrolled in Medicare because you would not be paid by Medicare for your services, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.

If you are a resident who has a medical license but have not enrolled in Medicare because you would not be paid by Medicare for your services, you do not need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. The teaching physician - not the resident - should be identified in claims as the ordering/referring provider when a resident orders or refers items or services for Medicare beneficiaries.

CMS actions to mitigate the number of informational messages:

Since many Part B providers and suppliers are receiving a high volume of informational messages in their Remittances, CMS is taking the following actions to reduce the number of informational messages being generated:

1. Prior to the implementation of Phase 2, CMS will systematically add the NPIs to the PECOS enrollment records of all physicians and non-physician practitioners whose enrollment records are in PECOS but do not contain their NPIs. Because the NPI is one of the matching criteria used in implementing the two new edits on the Ordering/Referring Provider, it is essential that the NPI be in the PECOS enrollment record. Because the data file used to implement the two edits contains only the eligible physicians and non-physician practitioners who are in PECOS with NPIs in their enrollment records, this action will add many more physicians and non-physician practitioners to that data file.

2. Prior to the implementation of Phase 2, CMS will make publicly available on the Internet the names and NPIs of the Medicare physicians and non-physician practitioners who are eligible to order or refer in the Medicare program. The name displayed will be that of the physician or non-physician practitioner as it appears in his or her PECOS enrollment record. This will allow Part B providers and suppliers who furnish and bill for items or services based on orders or referrals to determine if the Ordering/Referring Provider being identified in their claims will pass the two new edits prior to submitting the claims to Medicare.

3. Prior to the implementation of Phase 2, CMS will issue instructions to carriers and A/B MACs that will assist them in processing enrollment applications from physicians who are employed by the Department of Veterans Affairs, the Public Health Service, and the Department of Defense Tricare program. The instructions will also state that the teaching physician

should be reported as the Ordering/Referring Physician in situations where a resident orders or refers items or services for Medicare beneficiaries. The instructions will also note that dentists and pediatricians, who sometimes order or refer items or services for Medicare beneficiaries, may be enrolling in Medicare in order to continue to order and refer.

4. CMS will be preparing a Special Edition *Medicare Learning Network (MLN) Matters*® Article on the implementation of these two new edits. This *MLN Matters*® Article will expand upon the information currently available in *MLN Matters*® Articles MM6417 and MM6421.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program Round One Rebid Implementation - -Phase 8B: Oxygen Modality (OXY)

MLN Matters® Number: MM6692
Related CR Release Date: November 6, 2009
Related CR Transmittal #: R593 OTN

Related Change Request (CR) #: 6692
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Provider Types Affected
Suppliers submitting claims to Medicare Regional Home Health Intermediaries (RHHIs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for stationary or portable oxygen equipment provided to Medicare beneficiaries need to be aware of this article.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued CR 6692 to announce changes in the way grandfathered oxygen competitive bid claims are processed following a change in stationary or portable equipment modality under Round One of the DMEPOS Competitive Bidding Program. RHHIs and DME MACs are required to apply a single 36-month cap for stationary oxygen equipment and a separate single 36-month cap for portable oxygen equipment regardless of how many different HCPCS codes are billed for a beneficiary during the rental period. See the *Background* and *Key Points* sections below and make certain your billing staff is aware of these changes.

Background
The Medicare DMEPOS Competitive Bidding Program was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) which amended section 1847 of the Social Security Act (the Act) to require the Secretary to establish and implement programs under which CBAs are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Part B.

Section 1847(a)(4) of the Act requires that in the case of covered DME items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary establish a grandfathering process by which rental agreements for those covered items and supply arrangements with oxygen suppliers entered into before the start of a competitive bidding program may be continued. This grandfathering provision provides the beneficiary the choice of receiving a grandfathered item from a grandfathered supplier or a contract supplier. Unless the beneficiary elects to change suppliers, the rental agreements and supply arrangements for grandfathered items last for the duration of a beneficiary's medical need or for the items reasonable useful lifetime. In the case of oxygen and oxygen equipment, a change in stationary or portable oxygen equipment modality during the 36-month period does not start a new 36 month rental period and does not, in and of itself, terminate a supplier's role as a grandfathered supplier of oxygen and oxygen equipment.

Key Points of CR 6692

- For stationary oxygen systems **codes E0424, E0439, E1390, E1391, E1405, and E1406**, any change in modalities at any point during the 36-month rental payment period (i.e., from one HCPCS code for a stationary oxygen system to another) does not affect the status of a grandfathered supplier and its ability to continue billing and receiving payment for furnishing stationary oxygen and oxygen equipment to a beneficiary residing in a competitive bidding area (CBA) for whom it had furnished such stationary oxygen and oxygen equipment prior to the start of the competitive bidding program.

- For portable oxygen equipment **codes E0431, E0434, E1392, and K0738**, any change in modalities at any point during the 36-month rental payment period (i.e., from one HCPCS code for portable oxygen equipment to another) does not affect the status of a grandfathered supplier and its ability to continue billing and receiving payment for furnishing portable oxygen and oxygen equipment to a beneficiary residing in a CBA for whom it had furnished such portable oxygen and oxygen equipment prior to the start of the competitive bidding program.

- Previously CMS instructed that non-contract suppliers of stationary and portable oxygen equipment **may continue to provide their equipment to their existing beneficiaries, if the beneficiary agrees to the arrangement**. CMS also instructed that, if a non-contract supplier does not want to continue to provide oxygen equipment to its existing beneficiaries at the bid amount, the beneficiary must obtain the item from a contract supplier. If a beneficiary no longer rents a grandfathered item from his or her previous supplier (because the previous supplier elected not to become a grandfathered supplier or the beneficiary elected to change suppliers), a maximum of 45 rental payments may be made for portable oxygen equipment and up to 45 payments may be made for stationary oxygen equipment.

- In situations where a beneficiary in a CBA is receiving oxygen services via portable and/or stationary oxygen equipment prior to competitive bidding and the beneficiary's oxygen equipment and suppliers are not grandfathered (because the previous supplier chose not to be grandfathered or the beneficiary chose not to stay with that supplier), Medicare will allow for a minimum of 10 monthly rental payments to be paid to the contract supplier for any modality of portable and/or stationary oxygen equipment. In such cases, the beneficiary is liable for the co-payments for any additional payments made to the contract supplier.

Additional Information
If you have questions, please contact your Medicare 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.

The official instruction, CR6692, issued to your Medicare RHHI or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R593OTN.pdf** on the CMS Web site.

For an overview of the DMEPOS competitive bidding program you may go to **http://www.dmecompetitivebid.com** on the Internet.

Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs) (GEN)

MLN Matters Number: MM6421
Related CR Release Date: April 24, 2009

Related CR Transmittal #: R480OTN

Related Change Request (CR) #: 6421
Effective Dates: Phase 1 - October 1, 2009
Phase 2 - January 1, 2010
Implementation Date: Phase 1 - October 5, 2009
Phase 2 - January 4, 2010

NOTE: *This article was revised on September 14, 2009, to add clarifying language to emphasize that billed services requiring an ordering/referring provider on the claim must contain the ordering/referring provider under both phases of this change or the claim will not be paid.*

Provider Types Affected
Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for items or services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on change request (CR) 6421, which requires Medicare implementation of system edits to assure that DMEPOS suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare

Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact DMEPOS claims received and processed on or after October 5, 2009.

Background
CMS is expanding claim editing to meet the *Social Security Act* requirements for ordering and referring providers. Section 1833(q) of the Social Security Act requires that all ordering and referring physicians and non-physician practitioners meet the definitions at section 1861(r) and 1842(b)(18)(C) and be uniquely identified in all claims for items and services that are the results of orders or referrals. Effective January 1, 1992, a provider or supplier who bills Medicare for an item or service that was ordered or referred must show the name and unique identifier of the ordering/referring provider on the claim.

The providers who can order/refer are:

- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Chiropractic Medicine;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker.

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS with one of the above specialties.

Key Points

- **During Phase 1 (October 5, 2009-January 3, 2010):** If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will continue to process.**

    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.**

    2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.**

- **During Phase 2, (January 4, 2010 and thereafter):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.**

    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.**

    2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.**

- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.

- When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.

- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at **https://pecos.cms.hhs.gov/pecos/login.do** on the CMS Web site. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at **http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp** on the CMS Web site. Once at that site, scroll to the downloads section of that page and click on the materials that apply to you and your practice.

Additional Information
If you have questions, please contact your Medicare DME MAC at its 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, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R480OTN.pdf** on the CMS Web site.

Important Medicare Information about DMEPOS Supplier Accreditation and the Round 1 Rebid of the DMEPOS Competitive Bidding Program (GEN)

MLN Matters® Number: SE0925 - 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 September 28, 2009, to include (and emphasize) on page 3 an important section regarding voluntary and non-voluntary terminations/enrollments.*

Provider Types Affected
This article is for all suppliers that furnish Medicare Part B durable medical equipment, prosthetic devices, prosthetic or orthotic items and supplies (DMEPOS) to Medicare beneficiaries. Critical changes are coming that will affect the way Medicare pays for DMEPOS and how Medicare determines who can bill for DMEPOS. This article provides important reminders about some of these changes, which will be occurring in the very near future and how these changes affect suppliers who will participate in the DMEPOS competitive bidding program. Suppliers are urged to review this article and be sure they are prepared for these changes in order to continue providing DMEPOS to Medicare patients.

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) reminds Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers enrolled with the National Supplier Clearinghouse (NSC) they are required to obtain accreditation by October 1, 2009, unless exempt, and obtain a surety bond by October 2, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

What You Need to Know
If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. Voluntary termination allows you to re enroll once you meet the requirements to participate in the Medicare program. If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

What You Need to Do
Whether or not you plan to remain as a Medicare supplier, it is recommended that you review this information. **Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.**

Background
This article includes important reminder information for suppliers who will continue to serve as suppliers for Medicare beneficiaries on and after October 1, 2009.

Voluntary and Non-Voluntary Terminations/Enrollment
Medicare suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), unless exempt, must be accredited and obtain a surety bond by October 1, 2009 and October 2, 2009, respectively.

If you have made the decision not to obtain accreditation or a surety bond when required, you may want to voluntarily terminate your enrollment in the Medicare program before the implementation dates above. You can voluntarily terminate your enrollment with the Medicare program by completing the sections associated with voluntary termination on page 4 of the Medicare enrollment application (CMS-855S). Once complete, you should sign, date and send the completed application to the National Supplier Clearinghouse (NSC). By voluntarily terminating your Medicare enrollment, you will preserve your right to re-enroll in Medicare once you meet the requirements to participate in the Medicare program.

If you do not comply with the accreditation and surety bond requirements and do not submit a voluntary termination, your Medicare billing privileges will be revoked. A revocation will bar you from re-enrolling in Medicare for at least one year after the date of revocation.

Suppliers who do not plan to stay enrolled in Medicare are strongly encouraged to notify their beneficiaries as soon as possible so the beneficiary can find another supplier.

Accreditation
In a previous *MLN Matters*® article, SE0903, CMS informed suppliers of the importance of accreditation and the consequences of not being accredited on or before September 30, 2009. That article is at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf** on the CMS Web site.

If you have already been notified by an approved accrediting organization that each of your practice locations has been accredited, the accreditation organization will notify the NSC that your DMEPOS supplier practice locations have been accredited. However, DMEPOS suppliers who obtained accreditation after September 1, 2009 but before October 1, 2009, should submit proof of accreditation to the NSC via submission of an amendment to their CMS-855S.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at **http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp** on the CMS Web site.

Accreditation and DMEPOS Competitive Bidding
Suppliers choosing to participate in the DMEPOS Competitive Bidding Program must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

- **GET LICENSED:** Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the National Supplier Clearinghouse (NSC). As part of the bid evaluation, CMS will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

- **GET ACCREDITED:** Medicare DMEPOS suppliers, unless exempt, must be accredited by October 1, 2009. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS will not accept bids from and will not contract with suppliers that are not accredited by a CMS-approved accreditation organization for the applicable product categories.

- **GET BONDED:** Medicare DMEPOS suppliers, unless exempt, must obtain and submit a surety bond by October 2, 2009. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of surety companies from which a bond can be secured is found at the Department of the Treasury's "List of Certified (Surety Bond) Companies;" the Web site is located at **http://www.fms.treas.gov/c570/c570_a-z.html** on the Internet. When submitting your DMEPOS surety bond to the NSC, you are required to submit sections 1, 2A1, 12, and either 15 (if you are the AO) or 16 (if you are the delegated official) of the CMS-855S. By submitting the required sections of the CMS-855S, you will help to ensure that NSC is able to correctly associate your DMEPOS surety bond to your enrollment record.

Accessing the Processes for the Round 1 Rebid

On August 3, 2009 CMS issued the bidding timeline for the Round 1 Rebid of the DMEPOS competitive bidding program and initiated a comprehensive bidder education campaign. The CMS contractor, CBIC, is the focal point for bidder education. Please visit the CBICs dedicated Web site, **http://www.dmecompetitivebid.com/**, for important information, including bidding rules, user guides, frequently asked questions, policy fact sheets, checklists, and bidding information charts. The CBIC toll-free help desk, 1-877-577-5331, is open to help bidders with all of their questions and concerns. All suppliers interested in bidding are urged to sign up for e-mail updates on the home page of the CBIC Web site. The Round 1 Rebid will result in significant changes in the way Medicare pays for certain types of DMEPOS and it is critical that suppliers understand the process and what it takes to be eligible to bid.

In prior communications, CMS has described the processes for registering to use CMS systems. (See the *MLN Matters*® article, SE0915, at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0915.pdf** on the CMS Web site.) For the Round 1 Rebid, it is imperative that suppliers register so they will be able to participate in the bidding process for the categories of DMEPOS to be obtained **only** through the competitive bidding program.

Round 1 Rebid Registration Milestones

Suppliers should be well into, if not completely through, this registration process. Registering now allows the AO and/or BAO time to correct the supplier's NSC records if their name, date of birth, and SSN does not match what is on file with NSC. **CMS recommends that BAOs register no later than October 9, 2009, so that they will be able to assist AOs with approving EU registration. Registration will close on November 4, 2009, at 9:00 p.m. EST - no AOs, BAOs, or EUs can register after registration closes.** The legal name, date of birth, and Social Security number (SSN) of the AO and BAOs must match what is on file with the NSC in order to register successfully. To register, go to **http://www.dmecompetitivebid.com/** on the Competitive Bidding Implementation Contractor (CBIC) Web site.

If you have not started this process, please review the Individuals Authorized Access to the CMS Computer Services (IACS) Reference Guide at **http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/IACS_Reference_Guide.pdf/$FIle/IACS_Reference_Guide.pdf?Open&cat=Suppliers** for step-by-step instructions on registration. The CBIC Web site also has the following useful tools:

- A registration checklist;
- Quick Step guides; and frequently asked questions.
- All suppliers interested in bidding are urged to sign up for E-mail Updates on the home page of the CBIC Web site. If you have any questions about the registration process, please contact the CBIC Customer Service Center at 1-877-577-5331.

The target deadline for Authorized Officials interested in participating in the Round 1 Rebid to register was September 14, 2009. If you are an AO who has not yet registered - do it TODAY! Visit **http://www.dmecompetitivebid.com/** to register.

Additional Information

For more information on the DMEPOS competitive bidding program, visit **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/** on the CMS Web site. For additional information regarding DMEPOS accreditation or the provisions associated with a surety bond, go to **http://www.cms.hhs.gov/MedicareProviderSupEnroll** on the CMS Web site. Frequently Asked Questions (FAQs) on the surety bond requirement can be found on the NSCs FAQ page at **http://www.palmettogba.com/nsc** on the Internet.

Influenza Pandemic Emergency - The Medicare Program Prepares (GEN)

MLN Matters Number: SE0836 - Rescinded
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: *The Centers for Medicare & Medicaid Services rescinded this article on September 11, 2009.*

Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program - Phase 8C of Implementation: Repairs and Replacements (GEN)

MLN Matters® Number: MM6678
Related CR Release Date: November 6, 2009
Related CR Transmittal #: R592OTN
Related Change Request (CR) #: 6678
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Provider Types Affected
This article is for Medicare Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) suppliers who submit claims for Medicare payment to DME Medicare Administrative Contractors (DME MACs).

Provider Action Needed
This article is based on Change Request (CR) 6678 which provides instructions for contractors to allow any supplier with a valid Medicare billing number to furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries in a competitive bidding area (CBA). It also requires a supplier that replaces an item that is subject to the DMEPOS Competitive Bidding Program to be a contract supplier. Please make sure your billing staff know about the modifier changes related to repair and replacement of DME and DME parts. Those modifier changes are discussed in this article.

Background
The Medicare DMEPOS Competitive Bidding Program was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) which amended section 1847 of the Social Security Act (the Act) to require the Secretary of the Department of Health and Human Services to establish and implement programs under which CBAs are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Medicare Part B.

CR6678 provides instructions to the DME MACs for processing claims submitted with the new repair and replacement modifiers under the DMEPOS Competitive Bidding Program Round One Rebid. Specifically, the existing modifier for repairs and replacement of DME items, RP, was deleted from the Health Care Common Procedure Code Set (HCPCS), effective December 31, 2008. To distinguish between the repair and the replacement of an item, the following two modifiers were added to the HCPCS on January 1, 2009:

- RA - Replacement of a DME item; and
- RB - Replacement of a part of DME furnished as part of a repair

The new RA modifier will be used in the DMEPOS Competitive Bidding Program to identify claims for the replacement of an entire competitive bid item. The RB modifier will be used to denote the replacement of a part for repair purposes.

CR 6678 provides instructions to allow any supplier with a valid Medicare billing number to furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries in a CBA. In these situations, Medicare payment for labor will be made based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment, that are submitted with the RB modifier, will be based on the single payment

amount for the part if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.

CR 6678 also requires a supplier that replaces an entire item, submitted with the RA modifier that is subject to the DMEPOS Competitive Bidding Program, to be a contract supplier. For these items, Medicare payment will be based on the single payment amount for the item in the beneficiary's CBA.

Additional Information
If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the Centers for Medicare & Medicaid Services (CMS) Web site. The official instruction (CR6678) issued to your Medicare DME MAC may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R592OTN.pdf** on the CMS Web site.

In addition, all providers may find more detailed information about the competitive bidding program at **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/** on the CMS Web site.

Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception (GEN)

MLN Matters® Number: MM6677
Related CR Release Date: November 6, 2009
Related CR Transmittal #: R590OTN
Related Change Request (CR) #: 6677
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Provider Types Affected
This article is for hospitals that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for specific allowed competitively bid items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) to their patients on the day of discharge.

What You Need To Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6677 to announce that hospitals may furnish certain competitively bid Durable Medical Equipment (DME) items to their patients on the date of discharge without submitting a bid and being awarded a contract under the Competitive Bidding Program Round 1 Rebid. The DME competitive bid items that a hospital may furnish upon discharge as part of this exception **for Round 1 Rebid** are walkers and related accessories. Note that this applies to claims received upon implementation of the DMEPOS Competitive Bidding Program Round One. That date is January 1, 2011, but the date is subject to change.

Key Points of CR6677

- Hospitals may furnish walkers and related accessories to their patients on the date of discharge whether or not the hospital has a contract under the DMEPOS Competitive Bidding Program.
- Separate payment is not made for walkers and related accessories furnished by a hospital **on the date of admission** as payment for these items is included in the Part A payment for inpatient facility services.
- Hospitals as defined below may furnish walkers and related accessories to their patients for use in the home on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier.
- To be paid for walkers and accessories as a non-contract supplier, hospitals should **use the modifier "J4"** and the National Competitive Bidding (NCB) indicator on the claim line in combination with the following **HCPCS codes: A4636, A4637, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0154, E0155, E0156, E0157, E0158, and E0159**.

- Hospital claims submitted for these items, for which Medicare does not find a matching date of discharge will be denied with remittance advice messages B15 (Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying service/procedure had not been received/adjudicated.), M114 (This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding these projects, contact your local contractor.), and MA13 (Alert: you may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.). Prior to denying these DME claims, Medicare will hold the claim for up to 15 business days to await the arrival of the hospital claim with the related discharge date. If such discharge is not processed by the end of the 15 business days, the DME claim will be denied.

Background
Section 302(b) (1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended section 1847 of the Social Security Act (the Act) to require the Secretary to establish and implement programs under which competitive bidding areas (CBAs) are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Part B (the "Medicare DMEPOS Competitive Bidding Program").

On July, 15, 2008, section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the MMA and mandated certain changes to the competitive bidding program. One of these changes established an exception for hospitals from the competitive bidding program when they are furnishing certain items to their own patients during an admission or on the date of discharge.

A hospital under this exception **does not include a hospital-owned DME supplier**. Instead, a hospital is defined in accordance with section 1861(e) of the Social Security Act. A DME supplier that furnishes the DME item to the hospital, which then furnishes the item to the patient on the date of discharge, must be a contract supplier in the competitive bidding program.

Additional Information
If you have questions, please contact your Medicare 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. The official instruction (CR6677) issued to your Medicare FI, DME/MAC, or A/B MAC is available at **http://www.cms.hhs.gov/Transmittals/downloads/R590OTN.pdf** on the CMS Web site.

For discussion of the program instructions designating the competitive bidding areas and product categories included in the DMEPOS competitive bidding program round one rebid in CY 2009 you may review MM6571 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6571.pdf** on the CMS Web site.

The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round I rebid in 2009 can also be found at **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp** on the CMS Web site. Further information on the boundaries and list of zip codes for each competitive bid area (CBA) and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp** on the CMS Web site and following the link to the Competitive Bidding Implementation Contractor (CBIC).

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2010 (GEN)

MLN Matters Number: MM6690
Related CR Release Date: November 13, 2009
Related CR Transmittal #: R61GI
Related Change Request (CR) #: 6690
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

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) 6690, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for calendar year (CY) 2010.

2010 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 2010 deductible and coinsurance amounts are in the following table.

Table 1

2010 Part A - Hospital Insurance (HI)			
Deductible	**$1,100.00**		
Coinsurance	**Hospital**		**Skilled Nursing Facility**
	Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
	$275.00	$550.00	$137.50

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 2010 Part A premiums are listed in table 2, below.

Table 2

Voluntary Enrollees Part A Premium Schedule for 2010	
Base Premium (BP)	$461.00 per month
Base Premium with 10% Surcharge	$507.10 per month
Base premium with 45% Reduction	$254.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$279.40 per month

2010 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 2010, the standard premium for SMI services is $110.50 a month; the deductible is $155.00 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 6690, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R61GI.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.

CMS News Flash (GEN)

Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all state licensure requirements for DMEPOS and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. Suppliers must be accredited for a product category to submit a bid for that product category. Suppliers subject to the surety bond requirement must be bonded in order to bid. For more information on the Medicare DMEPOS Competitive Bidding Program, please visit **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS Web site.

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. All bids must be submitted in DBidS, the on-line bidding system, by 9 p.m. prevailing Eastern Time on December 21, 2009; all required hardcopy documents that must be included as part of the bid package must be postmarked by 11:59 p.m. on December 21, 2009. Registration for the Round 1 Rebid will close on November 4, 2009, at 9:00 p.m. EST - no AOs, BAOs, or EUs can register after registration closes. Suppliers that do not register cannot bid and are not eligible for contracts. If you are interested in bidding, you must designate one Authorized Official (AO) from those listed on the CMS-855S enrollment form to act as your AO for registration purposes. The Round 1 Rebid competitive bidding areas (CBAs), product categories, DBidS information, bidder charts, educational materials, complete RFB instructions, and registration information, can all be found at **http://www.dmecompetitivebid.com/**, which is the Competitive Bidding Implementation Contractor (CBIC) Web site.

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. All bids must be submitted in DBidS, the on-line bidding system, by 9 p.m. prevailing Eastern Time on December 21, 2009; all required hardcopy documents that must be included as part of the bid package must be postmarked by 11:59 p.m. on December 21, 2009. The Round 1 Rebid competitive bidding areas (CBAs), product categories, DBidS information, bidder charts, educational materials, complete RFB instructions, and registration information, can all be found at **http://www.dmecompetitivebid.com**, which is the Competitive Bidding Implementation Contractor (CBIC) Web site.

The revised publication titled *ICD-10-CM/PCS: An Introduction Fact Sheet* (August 2009), which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in print format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. To place your order, visit **http://www.cms.hhs.gov/MLNGenInfo/**, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." If you are unable to access the hyperlink in this message, please copy and paste the URL into your Internet browser. For more educational resources regarding the ICD-10-CM/PCS Coding System, please visit **http://www.cms.hhs.gov/ICD10/** on the CMS Web site.

The publication titled *ICD-10-CM/PCS Myths & Facts* (June 2009), which presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System, is now available in both downloadable and print formats from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. Visit **http://www.cms.hhs.gov/MLNProducts/** , to find this and several other ICD-10 products. Scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page" for print formats or click on "MLN Publications" for downloadable versions.

Flu Season Is Upon Us! Begin now to take advantage of each office visit as an opportunity to encourage your patients to get a flu shot. It's still their best defense against combating the flu this season. (*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 personnel can spread the highly contagious flu virus to patients. **Protect yourself. Don't Get the Flu. Don't Give the Flu. Get Your Flu Shot. 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 professionals, please go to **http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf** on the CMS Web site.

Medicare will cover immunizations for H1N1 influenza also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. H1N1 influenza vaccine is currently under production and will be available in the Fall of 2009. For more information, go to **http://www.cms.hhs.gov/H1N1** on the CMS Web site.

REMINDER:

Accreditation Time Frame for Pharmacies is January 1, 2010

DME MAC Jurisdiction A Local Coverage Determinations (LCDs)

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) at:
http://www.cms.hhs.gov/mcd/overview.asp

LCD and Policy Article Revisions - Summary for October 2009 (GEN)

Outlined below are the principal changes to several DME MAC 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.

Ankle Foot/Knee Ankle Foot Orthosis

LCD

Revision Effective Date: 12/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers
Deleted: GY modifier
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers

Policy Article

Revision Effective Date: 12/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information on code A9283
CODING GUIDELINES:
Revised: Instructions for coding A9283
Revised: Instructions for code L2770
Revised: Instructions for coding concentric adjustable torsion joints
Revised: Instructions for RT/LT modifiers

Knee Orthosis

LCD

Revision Effective Date: 12/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA/GZ modifiers
Revised: RT/LT descriptors
DOCUMENTATION REQUIREMENTS:
Added: Instructions for GA/GZ modifier use

Policy Article

Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Revised: Instructions for code L2770
Revised: Instructions for coding concentric adjustable torsion joints
Revised: Instructions for RT/LT modifiers

Nebulizers

LCD

Revision Effective Date: 12/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Language from *Program Integrity Manual* on timing of refills and shipping of supplies/medications

Revised: Coverage criteria for long-acting bronchodilators

HCPCS CODES AND MODIFIERS:

Added: GA and GZ modifiers

Revised: KX modifier descriptor

ICD-9 CODES:

Revised: ICD-9 codes that support medical necessity for J7605, J7606

DOCUMENTATION:

Deleted: KX requirements from J7605 & J7606

Added: Instructions for use of GA and GZ modifiers

Oral Anticancer Drugs

Policy Article

Revision Effective Date: 10/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: 208.92-209.36, 209.70-209.79 to accepted diagnoses for busulfan, capecitabine, cyclophosphamide, etoposide, melphalan, methotrexate, or temozolomide

CODING GUIDELINES:

Changed: SADMERC to PDAC

ICD-9 CODES THAT ARE COVERED:

Added: 208.92-209.36, 209.70-209.79 to accepted diagnoses for busulfan, capecitabine, cyclophosphamide, etoposide, melphalan, methotrexate, or temozolomide

Oral Antiemetic Drugs

LCD

Revision Effective Date: 12/01/2009

HCPCS CODES AND MODIFIERS:

Added: GA and GZ modifiers

Revised: KX modifier

DOCUMENTATION REQUIREMENTS:

Added: Instructions for use of the GA and GZ modifiers

Policy Article

Revision Effective Date: 10/01/2009

CODING GUIDELINES:

Changed: SADMERC to PDAC

ICD-9 CODES THAT ARE COVERED:

Added: 208.92 - 209.36, 209.70-209.79

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 Policy Article.*

CERT Errors - Oxygen (OXY)

The Comprehensive Error Rate Testing (CERT) contractor has been identifying a significant number of errors on claims for oxygen equipment. Most of the errors are due to insufficient documentation to support the medical necessity for the billed items. Based on reports received by the DME MACs, the documentation that the CERT contractor is looking for includes:

- Most recent CMN prior to the date of service (DOS) on the claim
- Report of the qualifying oximetry or arterial blood gas test listed on the CMN
- Physician visit note within 30 days prior to the initial certification date documenting the diagnosis for which the oxygen is prescribed
- Physician visit note within 90 days prior to the recertification date (if applicable)
- For claims subsequent to the recertification date, physician visit note supporting continued medical monitoring of oxygen use and needs

When suppliers receive a request from the CERT contractor on an oxygen claim, it is important to assure that all of these documents are included in the response. If any of these documents are not provided, it will likely result in a request for overpayment on the claim.

Coverage Reminder - Insulin Pump Qualification: Beta Cell Autoantibody Testing (SPE)

The Centers for Medicare & Medical Services (CMS) national coverage determination for infusion pumps (Internet-only Manual, Pub. 100-03, Chapter 1, Part 4, Section 280.14) and the External Infusion Pump local coverage determination (LCD) contain coverage criteria for continuous subcutaneous insulin infusions using an external insulin pump. Criterion B requires a positive beta cell autoantibody test. Recently the DME MACs have received questions about which tests are acceptable to meet the beta cell autoantibody coverage requirement.

There are a number of antibody tests available that are related to pancreatic cells and insulin. The following tests were recently reviewed to evaluate whether they would be acceptable in meeting the policy requirement:

- Insulin Autoantibodies (IAA)
- Islet Cell Cytoplasmic Autoantibodies
- Glutamic Acid Decarboxylase Auto Antibodies (GADA)
- GAD65 Autoantibodies
- ICA512 Autoantibodies
- Insulinoma-Associated-2 Autoantibodies (IA-2A)

After review, it has been determined that only Islet Cell Cytoplasmic Autoantibodies (ICA) would be acceptable to meet the beta cell autoantibody test requirement described in the External Infusion Pump LCD. The other listed tests would not be acceptable alternatives to justify reimbursement of an external insulin pump by Medicare.

Refer to the *External Infusion Pumps* LCD for additional information about coverage, coding and documentation of external insulin pumps and continuous subcutaneous insulin infusions.

Enteral Nutrition Supply Kits - Coverage Reminder (PEN)

Suppliers are reminded that supply kits used for the administration of enteral nutrition must match with the route of administration. The *Enteral Nutrition* LCD "Indications and Limitations of Coverage and/or Medical Necessity" section states:

> "**The feeding supply kit (B4034-B4036) must correspond to the method of administration** indicated in question 5 of the DME Information Form (DIF). If it does not correspond, payment for the billed code will be based on the allowance for the code relating to the method of administration specified on the DIF or the billed code, whichever is less. If a pump supply kit (B4035) is ordered and the medical necessity of the pump is not documented, payment will be based on the allowance for the least costly medically appropriate alternative, B4036.
>
> **The codes for feeding supply kits (B4034-B4036) are specific to the route of administration.** Claims for more than one type of kit code delivered on the same date or provided on an ongoing basis will be denied as not medically necessary."
> (Emphasis added.)

When billing for these codes, suppliers are reminded that the fees for these codes are all-inclusive. It is inappropriate to unbundle and bill separately for these items. The "Coding Guidelines" section of the *Enteral Nutrition* Policy Article states,

> "**The codes for enteral feeding supplies (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day. Codes B4034-B4036 describe a daily supply fee rather than a specifically defined "kit".** Some items are changed daily; others may be used for multiple days. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors. These supplies include, but are not limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc. These items must not be separately billed using the miscellaneous code (B9998) or using specific codes for dressings or tape. The use of individual items may differ from patient to patient and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding."
> (Emphasis added.)

There are usually not routine changes in the method of administration. It would therefore be unusual to see claims for differing supply codes. In the event of a modification in the route of administration, there should be information in the medical record to justify the change. In any event, only one supply code per day is allowed.

Refer to the *Enteral Nutrition* LCD and Policy Article for additional information on the coverage and billing of supplies.

CMS To Conduct Fifth Annual Medicare Contractor Provider Satisfaction Survey (MCPSS) starting in January 2010. To learn more about the MCPSS visit: **http://www.cms.hhs.gov/MCPSS**

FAQ - Power Mobility Devices - Supplier ATP Involvement (Revised December 2009) (MOB)

This is a revision of an article originally published in 2008. In addition to revising several questions and responses, the article incorporates the distinction between an ATP conducting the specialty evaluation and the supplier's ATP. The supplier's ATP will be denoted as sATP where applicable.

Q1: What is an ATP?

A1: An Assistive Technology Professional (ATP) is a designation of certification by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). Prior to January 1, 2009, RESNA maintained two certifications - Assistive Technology Supplier (ATS) and Assistive Technology Practitioner (ATP). Those certifications were combined into one - Assistive Technology Professional (ATP) - with a single certification examination, after January 1, 2009. An ATP is a service provider who analyzes the needs of individuals with disabilities, assists in the selection of appropriate equipment and trains the consumer on how to properly use the specific equipment.

Q2: Why does Medicare require "in-person" involvement in the selection of a rehab wheelchair?

A2: As one can see from the description of the ATP in Question 1, the sATP with experience and training in proper assistive technology selection is in an ideal situation to translate the functional information from the licensed certified healthcare professional (LCMP) specialty examination into a specific equipment selection for the beneficiary. An sATP must be involved with the selection of a Group 2 single or multiple power option power wheelchair, all Group 3, 4, and 5 power wheelchairs, and a push-rim power assist device for a manual wheelchair.

Q3: Clarify "employ" as it relates to an ATP within this policy.

A3: The sATP must be employed by a supplier in a full-time, part-time, or contracted capacity as is acceptable by state law. The sATP, if part-time or contracted, must be under the direct control of the supplier.

Q4: If a supplier has a part time or contracted ATP on staff, what type of special documentation would be needed in an audit to prove the credential?

A4: A supplier must show that the employee was working under the supplier's control and guidance. The supplier should also be able to provide evidence of the sATP certification upon request.

Q5: Would a supplier be asked to provide employment records in an MR audit?

A5: Yes, employment records, contracting agreements or credential records could be requested. These types of records do not need to be routinely submitted with a claim but must be available upon request.

Q6: What does it mean for the sATP to have direct, in-person involvement in the wheelchair selection process?

A6: It means to physically see and interact with the patient and to document that involvement. It is important that the record show how the sATP was involved.

Q7: Can the sATP sign off on the licensed/certified medical professional (LCMP) evaluation, detailed product description, or some other attestation to demonstrate compliance with the requirement?

A7: The medical policy does not mandate how suppliers document compliance with the ATP requirement. There must be evidence in the supplier's file of direct in-person interaction with the patient by the sATP in the wheelchair selection process. The supplier, LCMP or treating physician must document how the sATP is involved with the patient. The documentation must be complete and detailed enough so a third party would be able to understand the nature of the sATP involvement and to show that the standard was met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement. For example, if the sATP participates in the specialty evaluation conducted in a multi-specialty clinic, the sATP could request that the person conducting and documenting the specialty evaluation include their name and credentials in the final report - "Ms. Jones was evaluated today for a power mobility device. Taking part in the evaluation was Dr. Smith, Ann Jones, PT and Bill Doe, ATP from XYZ Mobility." As an alternative, the sATP can create a note documenting their involvement in the specialty evaluation process and that the recommendations reflect their input.

Q8: If the sATP is not present at the specialty evaluation with the therapist or physiatrist, but does assess the patient "in person" following the evaluation by the LCMP, such as during the home evaluation, does this fulfill the requirement for "involvement with the selection process"?

A8: If the sATP has direct contact with the patient and has been involved in the wheelchair selection process, the requirement is met, providing that the sATP interaction is clearly documented within the patient's file. If the sATP has not had direct in-person involvement in the wheelchair selection process, the requirement is not met and the KX modifier must NOT be added to the code.

Q9: How should the sATP document their involvement if their evaluation takes place at the office or the beneficiary's home?

A9: A critical component in the provision of a PMD is ensuring that the wheelchair and accessories selected are appropriate for the beneficiary and meet their unique, individual needs. This often includes taking trunk and limb measurements, seating and positioning needs, and other observations about the beneficiary and their ability to use a PMD. This interaction should be documented by the sATP conducting the evaluation and signed and dated by the sATP, including their credentials.

Q10: Must the sATP be present for the delivery, fitting, and/or patient training for the wheelchair provided?

A10: The policy states that the credentialed sATP must have direct, in-person involvement with the equipment selection process. The policy does not require that the sATP be present for delivery, fitting, and/or patient training for the wheelchair.

Q11: Can the sATP evaluation be conducted at the time of the PMD delivery to the beneficiary?

A11: No. The purpose of the sATP evaluation is determining the proper seating, accessories and other components of the PMD prior to ordering and delivery; therefore, conducting this evaluation at the time of delivery of the device to the beneficiary's residence is not consistent with the intent of this requirement.

Q12: A company employs an ATP, as well as a number of non-credentialed staff who have direct, in-person involvement with the selection process. Is it permissible for the sATP to review the staff's recommendations and sign concurrence to meet the requirement?

A12: The sATP must have direct in-person involvement with the wheelchair selection process. An sATP cannot simply "review" and "sign off" on non-credentialed staff work in order to meet the requirement.

Q13: Can the sATP select a product prior to the face-to-face examination by the physician and/or prior to the specialty evaluation by the LCMP?

A13: Since the role of the sATP is to assure that the equipment selected is appropriate to address the medical needs identified during the F2F examination and specialty evaluation process, it would be inappropriate to begin product selection prior to completion of the F2F examination or specialty evaluation. Any in-person sATP/beneficiary interactions prior to the F2F examination or specialty evaluation would not be considered sufficient to meet the LCD requirement.

Q14: An ATP candidate has taken the RESNA exam but at the time of the in-person evaluation has not yet received the credential. In the event of an audit, will the pending receipt of the sATP credential, retroactively dated to the day the test was taken, be considered compliant?

A14: The LCD requires that there must have been an evaluation by a properly credentialed, supplier-employed ATP. The sATP must have been certified as of the date of he/she performed the in-person evaluation of the patient. The sATP is not a credentialed ATP until receipt of the credential from RESNA. RESNA document will specify the effective date of the credential.

Q15: If an ATP employed by a supplier who has had direct in-person involvement in the wheelchair selection process for a patient leaves a company before the wheelchair is delivered, will the claim be considered compliant?

A15: Leaving the company employment would not invalidate what that person did while working as a RESNA-certified ATP. The patient's record must illustrate the previously employed sATP had in-person involvement with the wheelchair selection process.

Q16: Can an sATP perform any part of the face-to-face (F2F) examination process required for all PMDs or the specialty evaluation required for rehab wheelchairs?

A16: No.

Q17: If the sATP participated in the evaluation by means of a live video feed, would that be acceptable?

A17: Yes. Involvement of the sATP in the evaluation of the patient via a live video feed is acceptable for beneficiaries who reside in remote locations as long as the evaluation is conducted in accordance with the Telehealth requirements outlined in the Centers for Medicare and Medicaid Services (CMS) *Benefit Policy Manual* (Internet-Only Manual 100-2), Chapter 15, Section 270.

HCPCS K0823 Notification of Prepayment Review

NHIC, Corp, DME MAC Jurisdiction A Medical Review will continue its widespread prepayment medical review of random claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds). This review is based on the results of CERT (Comprehensive Error Rate Testing) analysis and recently completed quarterly reviews which established an average charge denial rate of 79.5 percent.

Subsequently, suppliers of the selected claims will be sent a Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 30 days of the date on the letter will result in claim denials.

Returned documentation should include the following per the *DME MAC A Supplier Manual* and the *Power Mobility Devices* (L21271) LCD:

- The seven element order signed and dated by the treating physician.
- The written detailed product description of device base and separately billed options / accessories signed and dated by the treating physician.
- The written face-to-face examination by the treating physician. If any of the face-to-face examination is conducted by an independent physical therapist (PT) or occupational therapist (OT), include an attestation that the PT/OT had no financial relationship with the supplier.
- Medical records describing the justification for the power mobility device and separately billed options / accessories.
- The on-site home assessment record.
- Proof of delivery of the items to the beneficiary.

It is important for suppliers to be familiar with the coverage criteria and documentation requirements. Please ensure when submitting additional documentation requests that all supporting medical necessity documentation is provided.

Suppliers are reminded to reference the following publications for documentation requirements:

- The January 11, 2008 educational article: *Power Mobility Devices Billing Reminder*
  http://www.medicarenhic.com/dme/articles/011108_pmd.pdf
- The November 05, 2009 educational article: *Power Mobility Devices - 7-Element Order*
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf
- The November 13, 2009 educational article: *Power Mobility Devices - Detailed Product Description - Clarification*
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/111309_dpd.pdf
- The *Power Mobility Devices* (L21271) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

Additional information on documentation requirements may be found in the Medical Review section of the DME MAC A web site at: **http://www.medicarenhic.com/dme/medical_review/mr_index.shtml**

Article Retired The below article, "*Male External Catheter - A4326 - Coding and Utilization Guidelines*", published on October 08, 2009 has been retired effective October 09, 2009.

Male External Catheter - A4326 - Coding and Utilization Guidelines (SPE)

Code A4326 describes a special type of male exdwelling catheter.

A4326 Male external catheter with integral collection chamber, any type, each

Products described by this code are made of plastic or rubber. They are designed to be washed and reused. One product described by this code is the AlphaDry System by AlphaDry Medical. The manufacturer's recommendation is that this product be replaced every 15 days.

Effective for claims submitted on or after November 1, 2009, the only products that may be billed using code A4326 are those that have undergone Coding Verification Review by the Pricing, Data Analysis, and Coding (PDAC) Contractor and that are listed in the DMECS Product Classification List on the PDAC web site.

Data analysis suggests that suppliers may be using this code incorrectly when they should be using code A4349 which is a standard male external catheter that is typically changed daily.

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

Questions concerning the coding of these products should be referred to the PDAC.

Oxygen FAQs (OXY)

Q1: Please clarify the date of service to be used when billing maintenance and service for oxygen. Does the date of service have to be the actual date of the visit? For example: The patient has oxygen stationary equipment that "capped out" on 12/01/08 which would make the first allowable maintenance and service billable on 07/01/09. However, the equipment has been serviced on 06/15/09. May a supplier bill for the 06/15/09 M&S visit on 07/01/09 or do they have to wait until maintenance is required again?

A1: The 2009 6-month maintenance and servicing payment for oxygen concentrators and transfilling equipment only applies when the supplier physically makes an in-home visit to inspect the equipment and the date of the visit falls on or after the 6 month anniversary date. In the example provided, the supplier would not be able to bill for an M&S payment on 07/01/09 for a service visit that occurred on 06/15/09. In this particular case, if the supplier physically makes another in-home visit to inspect the equipment between 07/01/09 and 12/31/09, they would be eligible to bill for the 6 month M&S payment. The date of service on the claim would be the date of the actual visit.

Q2: If a patient is past the 36 month rental period for oxygen equipment (i.e., payment for the equipment has capped) and the patient has a stationary concentrator, stationary liquid tank, and portable liquid cylinders in the home, what code(s) may be billed?

A2: Per the Oxygen Policy Article: If the patient has a stationary concentrator, portable liquid equipment, and a stationary liquid tank to fill the portable cylinders, when payment for contents begins, payment will only be made for portable liquid contents. The only code that may be billed is E0444 (portable liquid contents). Code E0442 (stationary liquid contents) must not be billed in this situation because the stationary tank is just used to fill the portable cylinders.

Q3: The Oxygen LCD includes a requirement that the patient be seen and re-evaluated by the treating physician within 90 days prior to recertification. The revision of the LCD that was released in June included a change in the coverage of oxygen if the required re-evaluation was not performed within the 90 day time frame but was performed at a later date. The previous policy stated that, in that situation, payment could be made for dates of service between the scheduled recertification date and the date of the late physician visit if the blood gas study criteria were met. The revised policy states that, in that situation, coverage would end when the Initial Certification period ended and would resume beginning with the date of the late physician visit. The effective date of the LCD revision was given as 01/01/09. Did these revised coverage criteria take effect on that date?

A3: Because of the short notice given for the policy revision and the change in payment rules, the effective date of this specific requirement will be claims with dates of service on or after August 1, 2009. This date is based on the June 19, 2009 public release date of the policy revision. This clarification will be incorporated in a future revision of the LCD.

Q4: If the required physician re-evaluation is not performed within 90 days prior to recertification but is performed at a later date, what should be entered as the Recertification Date on the Oxygen CMN?

A4: In that situation, the date of the late physician visit should be entered as the Recertification Date on the CMN.

Power Mobility Devices - 7-Element Order (MOB)

Medicare national and local policy specify that following completion of the face-to-face examination, the physician or treating practitioner must complete a written order containing seven specified elements. Suppliers have the option of providing physicians with a form that lists the seven elements, but which requires the physician to provide all of the requested information. One example of such a form is:

```
Beneficiary name: _____
Item ordered: _____
Date of face-to-face examination: _____
Diagnosis/condition relating to need for item: _____
_____
Length of need: _____
Physician signature: _____
Signature date: _____
```

It is not permissible for the supplier to "lead" the physician as to the type of equipment that is ordered. Some examples, not all-inclusive, of unacceptable 7-element orders are:

- A form with "power mobility device" already entered in Item Ordered field.
- A form with check-off boxes for various types of mobility assistive equipment.

A 7-element order with these or similar elements will be considered invalid and the claim for the power mobility device will be denied.

Refer to the *Power Mobility Devices* Local Coverage Determination and Policy Article for additional information on coverage and documentation.

Power Mobility Devices - Detailed Product Description - Clarification (MOB)

In a revision of the *Power Mobility Devices* Local Coverage Determination (LCD) that became effective on 10/01/2009, the requirements for the detailed product description were revised. The LCD states:

For the wheelchair base and each option/accessory, the supplier must enter all of the following:

- HCPCS code
- Narrative description of the HCPCS code
- Manufacturer name and model name/number
- Supplier's charge
- Medicare fee schedule allowance

The second element, the narrative description, does not have to be the full narrative of the HCPCS code. However, it must be sufficiently detailed to describe the features of the item that distinguish it from items billed with similar codes.

The requirement will be revised to state: Narrative description of the item. This change will be incorporated in a future revision of the *Power Mobility Devices* LCD. Because this is a liberalization of the requirement, it will have an effective date of 10/01/2009.

Refer to the *Power Mobility Devices* LCD and Policy Article for additional information on coverage, coding, and documentation.

Power Mobility Devices - Indicating Receipt Date of Documentation (MOB)

The Power Mobility Devices local coverage determination and policy article stipulate that suppliers must receive clinical documentation and the 7-element order within 45 days of completion of the face-to-face evaluation. According to the LCD, "A date stamp or equivalent must be used to document receipt date."

In a recent review of PMD claims two problems were identified. First, suppliers are not consistently applying a date stamp or equivalent to the documents received from the treating physician. Documentation of the receipt date is a key requirement of this policy to demonstrate compliance with the statutory timeliness requirement.

Second, suppliers often rely on a facsimile header that includes a date and time indicator as an alternative to a date stamp. However, there are often multiple facsimile header lines that are the result of documents being faxed back and forth between the supplier and treating physician. Consequently, it is often difficult to determine the actual date of receipt of the documents by the supplier.

Suppliers should review their process for documenting the date of receipt of the documentation related to PMDs and ensure that all documents clearly indicate the date that the documents were received. Suppliers who rely on fax header information should be especially vigilant to make sure that the receipt date is clearly indicated to avoid claim denials.

Reminder - Replacement of Power Mobility Devices (MOB)

Suppliers are reminded that replacement of power mobility devices (PMDs) under reasonable useful lifetime rules differ from other types of durable medical equipment. As detailed in Final Rule for Power Mobility Devices (*Federal Register*, Vol. 71, No. 65, April 5, 2006) and published in the October 2007 *Frequently Asked Questions - Power Mobility Devices* article:

Q7: If a new PMD is needed after 5 years of use, what documentation must be obtained? Must we start the complete process or just obtain a new order?

A7: **All new PMD requirements must be met. Many new products are available, the codes have changed, and a patient's functional status must be assessed through a face-to-face evaluation in order to establish need.**

When replacing a PMD after the 5 year reasonable useful lifetime is met, the beneficiary must meet all of the coverage requirements outlined in the local coverage determination (LCD) for PMDs, including a new 7-element order and face-to-face evaluation. Claims that do not meet the coverage, coding or documentation criteria will be denied.

Results of Widespread Prepayment Review of Claims for HCPCS Code E0652 (Pneumatic Compressor, Segmental Home Model with Calibrated Gradient Pressure)

The DME MAC A Medical Review Department concluded a widespread review of HCPCS code E0652 from June 2009 through September 2009.

The results of the quarterly review of the claims from June 1, 2009 through September 30, 2009 identified eight hundred sixty-five (865) claims of which two hundred sixty-three (263) were denied. This resulted in an overall Charge Denial Rate of 54.00%.

The following are the top five (5) reasons for denial:

- The equipment is considered not reasonable and necessary (69 claims)
- The prescription is incomplete (46 claims)
- Duplicate claims (43 claims)
- Equipment is same or similar to equipment already in use (38 claims)
- Claim not payable under Jurisdiction A (e.g., claim submitted to incorrect contractor) (16 claims)

The other reasons for denial are as follows: (51 claims)

- Patient eligibility (e.g., patient cannot be identified as Medicare insured; beneficiary not covered by Medicare; or beneficiary covered by another plan or HMO, etc.)
- Date of death precedes date of service
- Missing or incomplete supplier information
- Claim contains incomplete or invalid information (e.g., missing or incomplete diagnosis or condition)
- No response to medical records request
- The equipment was provided while the patient is in the nursing home
- Lifetime benefit maximum for equipment has been reached

The Local Coverage Determination (LCD) for *Pneumatic Compression Devices* (L11503) states in part:

Pneumatic Compression Devices are only covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers, prescribed by a physician and determination by the physician of the medical necessity which must include the following:

- The patient's diagnosis and prognosis;
- Symptoms and objective findings, including measurements which establish the severity of the condition;
- The reason the device is required, including the treatments which have been tried and failed; and
- The clinical response to an initial treatment with the device. The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters and ability of the patient (or caregivers) to apply the device for continued use in the home.

The medical documentation submitted for five hundred thirty-four (534) claims supported the medical necessity for a lower level item, thus the services were downcoded to the least costly alternative.

The *Pneumatic Compression Devices* (L11503) LCD states:

> "*When a segmented device with manual control of the pressure in each chamber (E0652) is ordered and provided, payment will be based on the allowance for the least costly medically appropriate alternative, E0651, unless there is clear documentation of medical necessity in the individual case. Full payment for code E0652 will be made only when there is documentation that the individual has unique characteristics that prevent satisfactory pneumatic compression treatment using a non-segmented device (E0650) with a segmented appliance/sleeve (E0671 - E0673) or a segmented device without manual control of the pressure chamber (E0651).*"

For any item to be covered by Medicare, it must:

- Be eligible for a defined Medicare benefit category;
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; and
- Meet all other applicable Medicare statutory and regulatory requirements.

Suppliers are reminded that documentation must be made available to the DME MAC upon request. Reference the following under the Documentation Requirements section in the *Pneumatic Compression Devices* (L11503) LCD, which states in part:

> "*Section 1833 (e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 13951 (e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.*"

Reference the following publications for documentation requirements for HCPCS code E0650 - E0652, the *DME MAC A Supplier Manual* and the *Pneumatic Compression Devices* (L11503) LCD. These are available on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/index.shtml**

Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds)

DME MAC A continues its widespread, pre-payment review of Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly widespread pre-payment probe reviews findings. The claims covered the period from October 01, 2008 through December 31, 2008 and resulted to a 67.62% Charge Denial Rate (CDR). Quarterly review findings for the period covering claims from January 01, 2009 through March 31, 2009 resulted to a 62.78% CDR. Based on the high CDR, all claims billed with HCPCS K0823 continue to be the subject of a pre-payment review.

DME MAC A recently concluded 2 additional quarterly pre-payment reviews. The results of the quarterly review for claims paid from April 01, 2009 through June 30, 2009, identified the following CDR:

- This review involved 510 claims submitted by 95 suppliers, of which, 148 claims were allowed and 362 were denied (70.98%). This resulted in an overall Charge Denial Rate of 71.74%

Based on review of the documentation received, the following are the primary denial reasons.

- • Determined to be medically unnecessary (50.0%) (examples)
    - Face to Face; not a physical exam; did not address mobility issue; not signed by physician
    - Upper extremity issues not addressed or ROM and strength indicated did not justify PWD
    - Documentation illegible
    - No objective findings and/or insufficient clinical findings to justify need of PWD
    - Indication patient able to walk
    - Indication patient in SNF
- Forms determined to be supplier generated pre-printed forms (39.5%) (examples)
    - 7 element partially supplier completed
    - Mobility Evaluation supplier formatted check off list
    - Face to Face supplier formatted questionnaire, not a comprehensive examination
- Incomplete 7 element order (5.52%)

The results of the quarterly review for claims paid from July 01, 2009 through September 30, 2009 identified the following CDR:

- This review involved 299 claims submitted by 60 suppliers, of which 46 claims were allowed and 253 were denied (84.62%). This resulted in an overall Charge Denial Rate of 87.27%

Based on review of the ADR documentation received, the following are the primary denial reasons.

- Determined to be medically unnecessary (62.06%) (examples)
    - Face to Face evaluation; not a physical exam; did not address mobility problems
    - Upper extremity issues not addressed or ROM and strength indicated did not justify PWD
    - No objective findings and/or insufficient clinical findings to justify need of PWD
    - Documentation identified patient injury / surgery, PWD required for rehab / post op period
- Forms determined to be supplier generated pre-printed forms (30.83%) (examples)
    - 7 element partially supplier completed
    - Mobility Evaluation supplier formatted check off list
    - Face to Face supplier formatted questionnaire, not a comprehensive examination
- Incomplete 7 element order (3.16%)

To justify the removal of a pre-payment edit, the error rate must reflect a reduction of 70 percent or more. Based on the above quarterly CDRs, DME MAC A will continue the current widespread prepayment review process of HCPCS K0823.

Suppliers are reminded to reference the following publications for documentation requirements:

- The January 11, 2008 educational article: *Power Mobility Devices Billing Reminder*
  http://www.medicarenhic.com/dme/articles/011108_pmd.pdf

- The November 05, 2009 educational article: *Power Mobility Devices - 7-Element Order*
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf

- The November 13, 2009 educational article: *Power Mobility Devices - Detailed Product Description - Clarification*
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/111309_dpd.pdf

- The *Power Mobility Devices* (L21271) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

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Tracheostomy Care Kit - Coding Guidelines (SPE)

Codes A4625 (Tracheostomy care kit for new tracheostomy) and A4629 (Tracheostomy care kit for established tracheostomy) describe supplies that are used to maintain a tracheostomy tube including the tracheostomy site. The items listed below are essential items that **must** be included in a tracheostomy care kit but may not be all-inclusive of items that meet the patient's needs. Quantities of items in excess of those listed and/or additional items (e.g. other types of surgical dressings) are included in the kit codes and may not be billed separately. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors.

A tracheostomy care kit for a new tracheostomy (A4625) contains, at a minimum, the following:

Item	Number Included
Plastic tray	1
Basin	1
Sterile gloves	1 pair
Tube brush	1
Pipe cleaners	3
Pre-cut tracheostomy dressing	1
Gauze	1 roll
4x4 sponges	4
Cotton tip applicators	2
Twill tape	30 inches

A tracheostomy care kit for an established tracheostomy (A4629) contains, at a minimum the following:

Item	Number Included
Tube brush	1
Pipe cleaners	2
Cotton tip applicators	2
Twill tape	30 inches
4x4 sponges	2

Usual Maximum Amount of Supplies (GEN)

Many of the DME MAC local coverage determinations (LCDs) have supplies or accessories with usual maximum quantities and frequency limits. Suppliers are not required to provide these amounts nor are beneficiaries required to accept supplies or accessories at this frequency or in quantities that exceed the amount they typically use. Reordering of supplies and accessories is based upon actual beneficiary usage. Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted.

A beneficiary or their caregiver must specifically request refills of supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined basis, even if the beneficiary has "authorized" this in advance. As referenced in the *Program Integrity Manual* (Internet-Only Manual, CMS Pub. 100-8, Chapter 4.26.1) "Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately 5 days prior to the end of usage for the current product."

Vacuum Erection Devices (L7900) - Documentation Requirements (O&P)

NHIC Corp., DME MAC Jurisdiction A Medical Review has recently received a number of questions regarding documentation of medical necessity for vacuum erection devices (L7900). Coverage for L7900 is provided under the Prosthetic benefit which stipulates that the device must be used to replace all or part of an internal body organ. In addition to the statutory requirements, the general documentation requirements as described in Chapter 10 of the *DME MAC A Supplier Manual* apply. For any Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) item to be covered:

The patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. Neither a physician's order, nor a supplier-prepared statement, nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item or information on a supplier-prepared statement or physician attestation (if applicable).

Often claims for these devices do not have diagnostic information that relates to organic impotence. For patients receiving a vacuum erection device, the physician evaluation would generally include a history and physical examination focused on defining the cause of the erectile dysfunction/impotence and treatment of any co-morbid conditions that may impact sexual function. This is important to assure that specifically treatable conditions are identified before ordering a vacuum erection device. Documentation of this evaluation, conducted prior to the date of service on the claim, must be available to the DME MAC upon request. For claims that meet these documentation requirements, in addition to the ICD-9 diagnosis code for organic impotence (607.84), it is recommended that providers also include a secondary diagnosis to identify the cause of the impotence.

Join the NHIC, Corp. DME MAC A ListServe!
Visit **http://www.medicarenhic.com/dme/listserve.html** today!

Ask-the-Contractor Teleconference (ACT) Q&A - September 30, 2009 (GEN)

The September 2009 ACT call was conducted as a teleconference and Webinar. DME MAC A provided general updates and then conducted an open Q&A chat session. As questions were submitted via the Webinar chat mechanism staff responded by sharing both the question and the answer with the entire audience. In addition, questions were solicited in advance during the registration process and addressed during the call. **Note:** *Individual claim specific questions are not included below. As advised during the call, please contact Customer Service to address these types of questions.*

Q1: Under the PAP guidelines, if a patient is not compliant in the first 3 months and as a result has a new sleep study performed and is still not compliant after the next 3 months is another sleep study necessary?

A1: Yes, a new sleep study would be required if attempting to re-qualify the patient.

Q2: What is the current ruling on consignment closets?

A2: Please refer to the *MLN* article *Compliance Standards for Consignment Closets and Stock and Bill Arrangements* (MM6528) at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6528.pdf** on the CMS Web site.

Q3: If a pharmacy sends an assigned claim for diabetic supplies with a GA modifier will the claim adjudicate for the allowed supplies and then return a PR responsibility for anything above Medicare's guideline?

A3: Yes, assuming the claim is accurate and complete and the beneficiary meets the medical necessity requirements, the claim will be paid for the allowable number of units. Any excess units will receive an over-utilization denial which will produce a PR denial when billed with a GA modifier.

Q4: Is it a requirement to give the patient the option of renting or purchasing a power mobility device (PMD) at the time of setup? Can we make it company policy to only sell PMDs and not offer the rent option?

A4: Giving the beneficiary the option to rent or purchase a PMD is a requirement; however, if you choose only to sell these items then you can advise the beneficiary that they could go to another supplier if they want to rent these items.

Q5: Can you clarify if it is acceptable to bill a 90 day supply for PAP supplies? If so, is a date span necessary with a note in the NTE field?

A5: Yes, it is acceptable to bill a 90 day supply. A date span must not be used on the claim line; however, you are required to document the appropriate dates for which the supplies are for in the NTE field.

Q6: Where can I find the published utilization limits for tracheostomy tubes (A7520/A7521) and other tracheostomy supplies?

A6: If there are specific utilization guidelines for an item it would be specified in the LCD. If parameters are not listed, utilization is based on individual consideration and may vary from patient to patient.

Q7: Are the upcoming pre-payment audits for oxygen going to involve only the first claim selected for a particular beneficiary or on each subsequent claim for the same beneficiary as well?

A7: The upcoming widespread prepayment probe audits will be conducted on a random sample of claims from multiple suppliers. For additional information on the Medical Review process access The *Medicare Medical Review Program* brochure available on the CMS *Medicare Learning Network* Web site at **http://www.cms.hhs.gov/MLNProducts/downloads/MedReviewProgbroch07.pdf**

Q8: If a claim is submitted for an item that requires the KX modifier to indicate coverage criteria is met but the KX is missing; is the claim denied or rejected? Can the KX be added accordingly and the claim resubmitted?

A8: In the past, absence of a KX modifier always caused the claim to deny and required a reopening or an appeal. The DME MACs are currently implementing new system edits that will now reject a claim line if not billed with the KX, GA, GY or GZ modifiers. If a claim line is rejected, the supplier may correct the claim and resubmit. These system and policy changes are being phased in and will be implemented for all LCDs with the KX modifier over the next few months. For additional information, refer to the DME MAC Jurisdiction A article: *IMPORTANT CHANGE - KX, GA, GZ and GY Modifiers - New Uses* on the DME MAC A Web site at **http://www.medicarenhic.com/dme/articles/072209_kx.pdf**

Q9: If a supplier has voluntarily revoked their NPI number due to non-completion of accreditation requirements; however, they have claims that need to be sent to reopenings, redetermination, etc. for dates of service prior to 09/30/09, can they still do so?

A9: Yes, as long as the date of service is prior to the deactivation of their NPI number.

Q10: If a patient requests to purchase a portable concentrator to have in addition to their stationary system, can we get an ABN and sell them the unit?

A10: It is expected that if the patient qualifies for the portable system that you would provide the portable and follow the rental guidelines; however, if the additional piece of equipment is a patient preference then an ABN can be obtained and the appropriate option selected. **Note:** *An item that is required to be billed as a rental cannot be billed to Medicare as a purchase.*

Q11: What is the Web site for the CERT Physician Letter for Oxygen and Supplies?

A11: **http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml**

Q12: Can we bill the patient for the purchase price of a CPAP when they are not compliant and they refuse to sign the ABN but won't return the machine?

A12: No.

Q13: For the CPAP requirement of 30 consecutive days, does this mean 30 days in a row?

A13: Yes.

Q14: Is something being considered to come up with a way for O&P providers to check for same/similar by calling the IVR?

A14: Currently, there is no way for suppliers to check for same/similar O&P items on the IVR. The supplier may initiate a 3-way call with the beneficiary and a customer service representative to verify if same/similar items are on file. NHIC is currently researching this issue for possible resolutions.

Q15: Have you ever considered splitting Webinars into categories? For example, have one for oxygen and then one for O&P so the information is specific to those specialty providers?

A15: We do offer specific Webinars for specific policies. This ACT call was intended for all supplier types to ask general questions pertaining to their particular business needs. The winter Webinar schedule is currently available by accessing the "*Events & Seminars*" section of the DME MAC A Web site at **http://www.medicarenhic.com/dme/dmerc_seminars.shtml#Online**

Q16: If the beneficiary did not return the ABN should I use the GZ modifier or still use the GA modifier?

A16: If you have not received a signed ABN back from the beneficiary you must bill with a GZ modifier; however, you may hold your claims until you receive the valid ABN.

Q17: Is testing on 4-LPM required if a patient is prescribed 6-LPM of oxygen? Is this also required to be reported on the CMN?

A17: Yes. To be considered for payment for higher liter flow, the patient must be tested on 4-LPM in order to comply with the high liter flow guidelines. This test result must be reported on question 6 of the CMN.

Q18: If we are billing as non-assigned for the PMD, are we still required to give the rent or purchase option to the patients receiving the PMD?

A18: Yes. For both assigned and non-assigned claims, the patient must be given the option to rent or purchase an item. A suggested form can be found on NSC Web site at **http://www.palmettogba.com/nsc**

Q19: If a patient is prescribed > 4-LPM of oxygen but we are not billing Medicare for the increased rate on the concentrator is it a requirement to have the patient tested on 4-LPM? Is it a requirement to report the testing on 4-LPM on the CMN if we are not billing for the increased rate?

A19: The supplier should be billing for what they are providing to the beneficiary. If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the patient is on 4-LPM meets Group I or II criteria. If a flow rate greater than 4-LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance.

Q20: If we are not billing for the increased rate on the stationary system, does the patient need to be tested on the 4-LPM?

A20: The supplier should be billing for what they are providing to the beneficiary. If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the patient is on 4-LPM meets Group I or II criteria. If a flow rate greater than 4-LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance.

Q21: If an ABN is mailed to a customer after the 31st day of treatment on a CPAP/BiPAP and the customer refuses to sign and mail the ABN back to the DME supplier, can the provider document the patient's refusal to sign the ABN in their records and then bill the claim with the GA modifier?

A21: No. You may not bill with the GA modifier unless you have received a valid ABN back from the patient.

Q22: I have a patient who received a CPAP at the ER and a face-to-face was not done before the sleep study. Per the LCD, this patient does not qualify since the face-to-face was not done prior to the sleep study and not done by the treating physician. Now the patient's primary physician is doing a face-to-face and ordering a new sleep study. Will Medicare cover the CPAP if the patient meets the criteria with the new face-to-face and the new sleep study, or will the first order done incorrectly always make this patient noncovered for PAP therapy?

A22: Medicare will consider the CPAP for coverage once all of the coverage criteria are met.

Q23: Can we file Medicare secondary payer claims by paper if we are submitting primary claims electronically?

A23: If you do not fit any of the current Administrative Simplification and Compliance Act (ASCA) exceptions, you are prohibited from submitting paper claims. To review these exceptions, refer to the *Administrative Simplification Compliance Act Self Assessment* found on the CMS Web site at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp**

Q24: Do we have to accept assignment for diabetic supplies even if we are a non-participating provider?

A24: No. Mandatory assignment only refers to drugs and biologicals.

Q25: We are a non-participating provider and are not required to accept assignment. Can we bill assigned and non assigned claims on the same dates of service for different HCPCS codes as long as they are on a separate delivery sheet?

A25: You must either accept assignment or not accept assignment for all items delivered on the same day. Suppliers should remember they may **not** attempt to "fragment" their bills. Fragmenting is defined as accepting assignment for some services and then billing the enrollee for other services performed at the same place and on the same occasion. There is an **EXCEPTION**. In situations where assignment is mandatory, i.e., where a supplier must accept assignment for certain services as a condition for any payment or for full payment to be made he/she may accept assignment for those conditional services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

Q26: Can you access same/similar information for diabetic shoes via the CMN status option in the IVR?

A26: No. Providers must speak directly with a customer service representative to obtain same/similar information on HCPCS codes beginning with the letters A, L or V. A three-way call with the beneficiary is necessary to obtain this information.

Q27: What options, if any, does the supplier have for noncompliant CPAP patients who refuse to sign an ABN?

A27: As the owner of the rented equipment, you can pick up your equipment if the patient does not meet compliance.

Q28: It was stated that DME has a 5 year useful lifetime rule and that an O&P items' useful lifetimes are in the LCDs. The question comes about when the LCD doesn't have a useful lifetime stated. The example we used was of a previous service for an L0627 that we were denied on for a 2009 date of service. Medicare stated that the patient already had same/similar equipment in use from 2007. We appealed the decision and showed the reason why she needed a different service, based on medical necessity. But again, there is no statement of useful lifetime within 5 years in the spinal LCD. So why would a provider get a same/similar denial on a spinal service within 2 years?

A28: Unless otherwise specified in the policy, all durable medical equipment (DME) and most O&P items will follow the 5 year useful lifetime rule.

Q29: The knee brace and the shoe policy include the useful lifetimes. Why wouldn't the system be able to give us same/similar information if Medicare is obviously keeping track of that when the claims come in? If a customer service representative can look that information up wouldn't there be a way to have the IVR give that information to us?

A29: Unfortunately, the IVR cannot provide same/similar information for O&P items. The mechanism used to track capped rental and inexpressive routinely purchased items is different than what is used for orthotics and prosthetics and is not accessible from the IVR. Providers must speak directly with a customer service representative to obtain same/similar information on HCPCS codes beginning with the letters A, L or V. A three-way call with the beneficiary is necessary to obtain this information.

Q30: We have been unable to locate information specific to mail order DME in relation to obtaining a signature for Assignment of Benefits (AOB). The *Medicare Claims Processing Manual* states, "*If it is impractical to obtain the patient's signature because a home health agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and indicate in the provider record "Patient not visited."*" (*Medicare Claims Processing Manual*, Publication100-04, Chapter 1, Section 50.1.3 A).

Does this same principal apply to a DME supplier that furnishes mail order DME via a delivery service such as Federal Express or UPS? Please note that the mail order DME does not involve any type of diabetic supplies.

A30: Please refer to the "Signature Requirements" section of Chapter 10 of the *DME MAC A Supplier Manual* for assignment of benefits signature requirements, which is found on the DME MAC A Web site at **http://www.medicarenhic.com/dme/suppmandownload.shtml**

Q31: How do you re- enroll with the NSC as a result of deactivation due to lack of claim submission?

A31: The reenrollment process allows the NSC to determine if the supplier is in compliance with the supplier standards.

The reenrollment process takes approximately 60 days, which includes a site visit, if required. Also, workload and the time spent requesting any additional information required to complete the reenrollment package play a part in determining the processing time. Be sure to respond to requests for information from the NSC timely to avoid having your supplier number inactivated and having to begin the process again.

The NSC has several tools available to assist suppliers through the reenrollment process. These include:

- *Helpful hints* for completing the CMS 855S (**http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/National%20Supplier%20Clearinghouse~Supplier%20Enrollment~Initial%20Enrollment~Helpful%20Hints%20for%20Completing%20the%20CMS%20855S?open**)

- Numerous *FAQs* regarding the enrollment process (**http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/National%20Supplier%20Clearinghouse~Supplier%20Enrollment~FAQs?open&expand=1**)

- Additional *helpful hints* regarding the reenrollment process (**http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/National%20Supplier%20Clearinghouse~Supplier%20Enrollment~Reenrollment~Helpful%20Hints%20Regarding%20the%20Reenrollment%20Process?open**)

You may also visit **http://www.palmettogba.com/nsc** for further information on reenrollment.

Q32: When will DMEPOS suppliers from the states of NY and NJ have to enroll in the Competitive Bidding Program?

A32: Certain NY and NJ providers will be affected for Round 2. Competition for Round 2 begins in 2011. On January 08, 2008, CMS announced the metropolitan statistical areas (MSAs) for Round 2. A list is available on the CMS Web site at: **http://www.cms.hhs.gov/DMEPOSCompetitiveBid**

Q33: When will Round 2 of the Competitive Bidding Program be announced and what will be the Competitive Bidding Areas (CBAs)?

A33: MIPPA provides that the delayed Round 2 competition will occur in 2011. Round 2 CBA specific zip codes are not yet available.

Q34: Are wheelchairs and transport chairs considered same/similar equipment?

A34: Yes, wheelchairs and transport chairs are considered to be same/similar equipment. You can retrieve same/similar information on these items via the Interactive Voice Response (IVR). Select option 7 from the IVR menu.

Q35: How is a CBA segmented? City, County or State?

A35: A CBA is segmented by counties and zip codes.

Billing Reminder: Submitting Claims for DME Replacement Items Broken Beyond Repair (GEN)

Replacement refers to the provision of an identical or nearly identical item. Replacement of an item during the five year reasonable useful lifetime is only covered if the item is lost, irreparably damaged, or the patient's medical condition changes and the item no longer satisfies the medical needs of the patient.

Replacement Due to Loss or Irreparable Damage
Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage is a rare unexpected event or natural disaster (i.e., fire, flood, etc.) that is an exception to the reasonable useful lifetime guideline. Medicare will consider irreparable damage when an item is damaged beyond repair by a specific incident or accident. A physician's order and/or new Certificate of Medical Necessity (CMN) (if applicable) is necessary to reaffirm the medical necessity of the item.

Replacement Due to Irreparable Wear
Replacement due to irreparable wear during the five year reasonable useful lifetime is not acceptable and is considered noncovered by Medicare. Irreparable wear is deterioration of an item due to day-to-day usage over time and a specific event cannot be identified that caused the deterioration. For example: if a patient utilizes a power wheelchair on a daily basis and the drive motor in the power wheelchair breaks down within three years due to irreparable wear, a replacement chair would not be covered because there was no specific incident that could be identified that caused the motor to break down. In this situation, Medicare will cover a repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary.

RA Billing Modifier
Specific modifiers are required when billing a claim for replacement items provided within the five year reasonable useful lifetime.

RA - Replacement of a DME item (For dates of service on or after January 1, 2009)
RP - Replacement and repair modifier (For dates of service prior to January 1, 2009)

Suppliers should use the **RA** modifier only on the first month claim to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. When billing with the **RA** modifier, documentation must be maintained in the beneficiary's files and be available upon request from the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The following documentation must be included, but is not limited to:

- Reason for replacement
- New CMN (if applicable)
- Medical records
- Police reports
- Written explanations from the beneficiary

Billing Examples
There must be specific information notated in the NTE 2300 segment of the electronic claim in order for Medicare to consider coverage. This includes all of the following information:

- The description of the beneficiary owned base piece of equipment that the item is being replaced on
- The HCPCS code of the base piece of equipment
- The date of purchase of the base piece of equipment

When submitting claims for items broken beyond repair it is necessary for information to be noted in the NTE 2300 segment of the electronic claim or Item 19 of a paper claim. To access a "suggested list" of abbreviations that will help you to maximize the effectiveness of the limited space available in the note segments visit: **http://www.medicarenhic.com/dme/ediabbrev.shtml**

The below example represents how to enter information for items that are broken beyond repair and are being replaced:

Example: "RPL K0004 MWC PUR 110506 BBR"

Note: This article does not apply to oxygen replacement equipment. Please refer to the article titled, "Medicare Billing Requirements and Policies for Replacement of Oxygen Equipment and Oxygen Contents" on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/articles/013009_oxy.pdf**

Fax Submission Tips and Reminders (GEN)

DME MAC Jurisdiction A receives many incoming faxes on a daily basis and would like to offer the following suggestions to ensure a smooth process:

- When requesting a reopening of a claim, please use the "Fax Reopening Cover Sheet" located on our web site at: **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms**. This completed form assists in the accurate filing of your request.

- Please complete the "Request for Redetermination Form (CMS 20027)" at: **http://www.medicarenhic.com/dme/dme_forms.shtml#CMSForms** when requesting a redetermination. A copy of the Remittance Advice for the claim in question should be included as well as any other documentation to support your request.

  Note: *You will not receive an acknowledgement letter if you are faxing your redetermination request. Your fax confirmation will serve as the acknowledgement that we received your request.*

- If you are not completing the above forms for a reopening or redetermination request, please be sure your fax provides your supplier name, the supplier PTAN, the beneficiary's name and HICN, the date of service in question and a clear and complete explanation of the issue.

- Written Inquiries must include the following information for authentication purposes:
  - NPI - National Provider Identifier; and
  - PTAN - Provider Transaction Access Number; and
  - Provider's last 5-digits of TIN (Tax Identification Number); or
  - Official Letterhead - name and address of practice location

- Only requests that are for an "immediate offset" should be faxed directly to **781-741-3916**. These requests will receive priority processing. Faxing other types of requests to this number may cause delays in processing.

- Please be sure your office receives a confirmation on each fax submitted and it indicates that all pages faxed were received. Only complete faxes will be submitted for processing.

- Please do not send duplicate fax submissions. If you receive a confirmation for your original fax, it has been received by us and it will be processed accordingly.

- Please do not fax documents that have been highlighted as these items are illegible when received.

- Please consider mailing requests with multiple pages. Depending on the size of the package and the condition of the documentation, mailing the package may be a better option than faxing. Contact information, including mailing addresses can be found on our web site at: **http://www.medicarenhic.com/dme/contacts.shtml**

Going Green - An Electronic Environment (GEN)

NHIC, Corp. DME MAC A would like to remind suppliers of the benefits of an electronic environment as a result of submitting electronic claims, receiving Electronic Remittance Advices (ERAs), using Medicare Remit Easy Print (MREP), and enrolling in Electronic Funds Transfers (EFTs).

Benefits of Electronic Claims
Medicare claims submitted electronically, via Electronic Data Interchange (EDI), have the benefits of being filed faster, more efficiently, and more cost-effectively than paper claims. Suppliers who do not bill claims electronically should consider the following advantages of EDI:

- 14-day payment floor versus 29-day payment floor for paper claims
- Increased accuracy and minimized rejections - direct processing (processors do not re-key claims)
- Online claim status verification/eligibility
- Ability to submit claims seven days a week, including holidays (excluding system maintenance)
- A contractor dedicated solely for EDI support for faster problem resolution
- Free software: **http://www.ngscedi.com/forms/formsindex.htm**

Electronic billing is available to both participating and non-participating suppliers as well as accepting assigned and non-assigned claims.

Electronic Remittance Advice (ERA)
Another benefit of electronic billing is the ERA. An ERA is available to the supplier several days sooner than the paper remittances, which arrive in the mail. When a vendor billing software is used, the remittance information can be interpreted by the supplier's computer system and automatically posted to the patient's account. Several clerical posting steps can be abbreviated or eliminated.

To sign up for ERAs, suppliers will need to sign and return a "*Submitter Action Request From*" (**http://www.ngsmedicare.com/OnlineForms/CEDISubmitterActionRequest.aspx**) to the CEDI Contractor.

For further information on the Remittance Advice refer to the "*Understanding the Remittance Advice: "A Guide for Medicare Providers, Physicians, Suppliers, and Billers*" (**http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf**) on the Centers for Medicare & Medicaid Services (CMS) Web site.

Medicare Remit Easy Print (MREP) Software
Save TIME and MONEY by taking advantage of FREE MREP software available for viewing and printing the ERA!
The MREP software gives providers and suppliers the following abilities:

- Easy navigation and viewing of the ERA using your personal computer
- Print the ERA in the SPR format
- Search capability that allows providers and suppliers the ability to find claims information easily
- Print and export reports about ERAs including denied, adjusted, and deductible applied claims
- Easy-to-use method to archive, restore, and delete imported ERAs

Providers and suppliers can view and print as many or as few claims as needed. This FREE software can save you time resolving Medicare claim issues. Take advantage of the MREP features unavailable with the SPR. **Get started today!**

For further information and to download MREP software refer to the **Medicare Remit Easy Print** section of the CMS Web site at **http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp**

Electronic Funds Transfer (EFT)
With EFT, Medicare will send payments directly to a provider's financial institution. All Medicare providers may apply for EFT.

There are many benefits of EFT including:

- Reduction of the amount of paper in the office
- Valuable time savings for staff and avoidance of hassle associated with going to the bank to deposit Medicare check
- Elimination of the risk of Medicare paper checks being lost or stolen in the mail
- Faster access to funds; many banks credit direct deposits faster than paper checks
- Easier reconciliation of payments with bank statements

For further information and to enroll in EFT refer to the Electronic Funds Transfer section of the NHIC, Corp DME MAC A Web site at **http://www.medicarenhic.com/dme/eft.shtml**

Important Reminder: DME MAC Information Forms for Enteral Nutrition (PEN)

The DME MAC A appeals area has identified a number of appeals for enteral nutrition that could have been prevented by submission of proper DME MAC Information Forms (DIFs) on the front end. The following DIF requirements are listed in the *Enteral Nutrition* LCD.

A new Initial DIF for enteral nutrients is required when:

1. A formula billed with a different code, which has not been previously certified, is ordered, or
2. Enteral nutrition services are resumed after they have not been required for two consecutive months.

A new Initial DIF for a pump (B9000 or B9002) is required when:

3. Enteral nutrition services involving use of a pump are resumed after they have not been required for two consecutive months.
4. A patient receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump.

A revised DIF for enteral nutrients is required when:

1. The number of calories per day is changed, or
2. The number of days per week administered is changed, or
3. The method of administration (syringe, gravity, pump) changes, or
4. The route of administration is changed from tube feedings to oral feedings (if billing for denial).

Based on the above LCD requirements, there are some situations which require the completion of two DIFs for proper claim adjudication.

Example 1: *A patient has an order change to add nutrient B4154 and at the same time the calories for the B4150 increase.*
DIF Requirements: *A new initial DIF is required for the B4154 and a revised DIF is required for the B4150. If both are submitted on an Initial DIF, the DIF for the B4150 will reject on the front end due to a previous initial on file. The B4150 will continue to pay based on the calories on the Initial DIF in the system. This will result in an underpayment of B4150 which would need to be appealed but could have been prevented by proper DIF submission.*

Example 2: *A patient is switched from gravity feedings to feedings via the pump. The same nutrient will be given via the pump.*
DIF Requirements: *An Initial DIF is required for the pump. The nutrient requires a Revised DIF to reflect the change in method of administration. If both are submitted on an Initial DIF, the DIF for the nutrient will reject on the front end due to a previous Initial DIF on file.*

Additional Tips to Prevent Rejections:

- Use the IVR to identify which DIFs are on file and identify the correct initial dates. The IVR is available at: 866-419-9458. Use Option 3 to confirm DIF details, including the initial and revised dates.
- Be sure the Initial Date on the Revised DIF matches the Initial Date on the Initial DIF on file, otherwise the DIF will reject.
- Be sure to check your CMN Reject Listing Report to identify the reason for any DIFs rejected on the front end. Descriptions of all codes on the CMN Reject Listing Report are in the *DME MAC Front End Edit Error Code Manual* available on the CEDI Web site (**http://www.ngscedi.com/**) under Resource Materials.

Overpayments - Frequently Asked Questions (GEN)

DME MAC Jurisdiction A receives many questions from the supplier community about the overpayment process - such as what form to use, how to request immediate offsets and other receivable related questions. DME MAC A would like to share some of the frequently asked questions with you to supplement the information found in Chapter 9 of the *DME MAC Jurisdiction A Supplier Manua*l at: **http://www.medicarenhic.com/dme/suppmandownload.shtml**

Immediate Offsets

Q: We have received a demand letter for an overpayment. How do we request an immediate offset?

A: You must complete the Immediate *Offset Request Form*, which is included as page 5 of the demand letter that you received from Medicare. It is important that you complete all of the information that is requested on the form and also include the first page of the demand letter which identifies the Document Control Number (DCN) of the particular overpayment in question. Fax the requested information back to **781.741.3916**. It is not necessary to use a fax cover sheet.

If you cannot locate the Immediate *Offset Request Form* on page 5 from the original demand letter you must use the *DME MAC A Offset Request Form* (**http://www.medicarenhic.com/dme/dme_forms.shtml#Forms**). Complete the form as noted above and fax it back with the first page of the demand letter. It is not necessary to send the entire demand letter or any other documents. **Note:** *The Immediate Offset Request Form found in a demand letter should only be used to request offsets for the specific Document Control Number (DCN) in that letter.*

Q: We asked for an immediate offset on a receivable and now we have received a second demand letter indicating interest has been added. What happened?

A: Having an immediate offset on a receivable does not automatically pay it off nor does it stop interest from accruing. Offsetting means that when any claim payment is due to you the money will first be applied to any open debts that are in offset mode followed by any remaining balance paid out. As long as a receivable is greater than $0, interest will accrue and a second demand letter will be issued.

Q: We faxed our request for an immediate offset before the date in which interest should have been added; however we were still charged interest. How can this problem be prevented?

A: If you are going to request an immediate offset it is important that you send it in **as soon as possible** after you receive your demand letter. By doing this, even if there are no claims payments scheduled for a few days, the receivable still might offset before interest accrues. Interest begins on day 30.

Overpayment Notification

Q: We have discovered an overpayment and would like to have the adjustment made and a receivable set up. We are not sending a check at this time. What is the proper procedure?

A: Complete the *Overpayment Refund Form.* It is important that you complete all of the information that is requested on the form. Pay close attention and be sure to check box that indicates "Immediate Offset Requested", which is located about half-way down the right side of the form. After completion, fax the form back and include the Remittance Advice page(s) emphasizing the specific claim(s) to be adjusted to **781.741.3916**. **Note:** *Be sure to remove PHI for all non-related beneficiary claims that are listed on the same Remittance Advice.*

Q: We have discovered an overpayment and would like to voluntarily send a refund check. What is the proper procedure?

A: In order for the check to be properly recorded and applied, complete the *Overpayment Refund Form* available on the DME MAC A Web site. For additional information on voluntary refunds, refer to page Chapter 9, page 9-2 of the *DME MAC A Supplier Manual* (**http://www.medicarenhic.com/dme/suppmandownload.shtml**).

Offset

Q: How can a supplier know if a receivable has been paid by offset?

A1: You can access the DME MAC A Interactive Voice Response (IVR) automated system to find the offset status of a receivable. Refer to the *DME MAC A IVR User Guide* (**http://www.medicarenhic.com/dme/contacts/DME_MAC_A_IVR_User_Guide.pdf**) for additional instructions on this process. Option 5 (Financial) will help you identify details about offsets and voluntary refunds.

A2: Notification of offsets will display at the bottom of your Remittance Advice with the notation **WO:** followed by the FCN/DCN of the debt(s) the money was applied to and the amount applied.

Q: Can payments from other DME MAC Jurisdictions be used to offset for suppliers that rarely bill DME MAC A?

A: No. If you do not bill Jurisdiction A very often and an overpayment exists that is aging you should call the IVR for a current balance and send a refund check as soon as possible. Failure to do this will result in interest accruing.

General

Q: What happens if a receivable is not paid or offset?

A: As described in the first demand letter (days are counted from the date of the first demand letter):

- At 30 days you will receive a second demand letter and interest for the first 30 days is added to the balance
- At 40 days the debt will automatically move into offset status
- Between 110 and 120 days you will receive a third letter, an "Intent to Refer" letter, which states that after 60 additional days any balance outstanding on the debt will be referred to the United States Treasury for collection
- At 180 days the debt will be referred to Treasury for collection

Q: What overpayment information can be obtained from the IVR?

A: Please reference the *DME MAC A IVR User Guide* located on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/contacts/DME_MAC_A_IVR_User_Guide.pdf**. Option 5 (Financial) will help you identify details about offsets and voluntary refunds.

PECOS Ordering/Referring Provider Case Sensitive Edits (GEN)

CEDI has front end edits in place to validate the data submitted conforms to HIPAA and Medicare requirements. As part of these edits, the Common Electronic Data Interchange (CEDI) utilizes external code sources to validate the data on inbound transactions. The Provider Enrollment, Chain and Ownership System (PECOS) file used to verify eligibility for ordering/referring providers is one of the external data code sources utilized by CEDI.

The information from PECOS is provided to CEDI using only upper case characters. The alpha character data on the claim for the ordering/referring provider must be in upper case in order to validate the name against the PECOS file.

CEDI will reject inbound transactions submitted with lower case characters where the external code source used to perform the edits is only provided in upper case. If a lower case character is submitted in the ordering/referring provider field, the claim will be rejected.

CEDI strongly encourages submitting all alpha characters in upper case to avoid this type of issue.

For more information and questions, please contact the CEDI Help Desk at **ngs.cedihelpdesk@wellpoint.com** or at **866-311-9184**

Reminder - Unprocessable (Return/Reject) Claims Must Be Resubmitted (GEN)

If a claim contains incomplete or invalid information it is returned as unprocessable or rejected. The easiest way to identify a rejected claim is with the following Claim Adjustment Reason Code (CARC):

CO-16: Claim/service lacks information which is needed for adjudication.

Unprocessable claims do not have reopening or redetermination rights and must be corrected and submitted as a new claim due to the fact that the initial claim is missing important information that is needed for processing or the claim information that was submitted is invalid.

Note: Resubmitting an unprocessable claim will not cause a duplicate denial as long as the item being billed was not previously paid for the same beneficiary with the same date of service.

For additional information on determining what claims are accepted via the reopenings process, please access Chapter 8 of the *DME MAC A Supplier Manual* at: **http://www.medicarenhic.com/dme/suppmandownload.shtml**

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

Third Quarter 2009 - 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 2009, are provided in the following table.

*** This information is now provided to all DME MACs by the CEDI contractor; therefore, the "Number Received" column contains a combination of results from all four DME MACs. As a result, this causes the number to be significantly higher than in previous reports.**

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 Invalid Procedure Code and/or Modifier	263,524	The procedure code, modifier, or procedure code and modifier combination is invalid.
C008 EIN/SSN Not On File w/ National Provider Identifier (NPI)	82,964	The Tax ID (Employer Identification Number/Social Security Number) that was submitted does not match what is on file with the NPPES or the National Supplier Clearinghouse (NSC).
C003 Billing NPI Not Found on Crosswalk	74,611	There is no link between the NPI that was submitted and a PTAN/NSC.
C095 Diagnosis Code Invalid - Pointer 1	61,910	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
C044 Subscriber Primary ID Invalid	47,129	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
B108 Billing provider not authorized for submitter	46,961	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C143 Ordering Provider ID Qualifier Invalid	45,283	The Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line.
C171 Capped Rental - Modifier Missing	40,791	The item (whether for purchase or rental) is classified as a capped rental item (or possibly a pen pump item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.
C147 Secondary ID Invalid	38,414	The Ordering Provider secondary identifier is invalid.
C179 Service From/To Dates Not Equal	26,695	The procedure code submitted for this line does not allow for spanned dates of service. Verify the "from" and "to" dates for this line are equal.

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 2009. 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 2009.

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.	7,509
CO 16 N51 Electronic interchange agreement not on file for provider/submitter.	The PTAN/NSC on file is not eligible to submit electronic claims.	4,078
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.	3,241
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	2,201
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).	2,096
CO 182 N56 Procedure modifier was invalid on the date of service.	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	1,927
CO 16 N286 Missing / incomplete / invalid referring provider primary identifier.	**Item 17A** - Physician UPIN (Unique Physician Identifier Number) submitted in error. Physician NPI must be submitted in Item 17B.	1,745
CO 16 N257 Missing / incomplete / invalid billing provider/supplier primary identifier.	**Item 33** - Provider Transaction Access Number (PTAN) number submitted in error. Must submit National Provider Identifier (NPI).	1,597
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.	1,272
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	1,269

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!

Supplier Manual News (GEN)

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 *Supplier Manual* is available to current suppliers 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 October of 2009 **chapters 1, 2, 4, 5, 8, 10 and 12** of the *DME MAC A Supplier Manual* were updated. In November of 2009 Chapter 1 was revised further. 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. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

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

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/listserve.html

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.

2010 DME MAC A Office and Call Center Holiday Schedules (GEN)

The **NHIC, Corp. DME MAC A Offices** will be observing the following holidays in 2010:

2010 NHIC Corp. DME MAC Jurisdiction A Holiday Schedule		
New Year's Day	Friday	January 1
Martin Luther King, Jr. Day	Monday	January 18
Presidents Day	Monday	February 15
Memorial Day	Monday	May 31
Independence Day	Monday	July 5
Labor Day	Monday	September 6
Thanksgiving Day	Thursday	November 25
Day after Thanksgiving	Friday	November 26
Christmas Eve	Friday	December 24
New Year's Eve	Friday	December 31

The **NHIC, Corp. DME MAC A Call Center** will be observing the following holidays in 2010:

2010 NHIC Corp. DME MAC A Call Center Holiday Schedule		
New Years Day	Friday	January 1
Martin Luther King Jr. Day	Monday	January 18
President's Day	Monday	February 15
Memorial Day	Monday	May 31
Independence Day	Monday	July 5
Labor Day	Monday	September 6
Columbus Day	Monday	October 11
Veterans Day	Thursday	November 11
Thanksgiving Day	Thursday	November 25
Day after Thanksgiving	Friday	November 26
Christmas Day	Friday	December 24

Be sure to have the most updated versions of the *DME MAC A IVR User Guide* and *DME MAC A IVR Call Flow* in your office, both can be found at **http://www.medicarenhic.com/dme/contacts.shtml**

For Your Notes

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

Helpful Contacts

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 Jurisdiction A 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: I*nclude both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Redetermination Requests Fax: 781-741-3118

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

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

Faxed Reopenings: 781-741-3914

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

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@hp.com

LCD Reconsiderations Mailing Address:

Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:

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**

There is now only one address for submitting all paper claims to DME MAC A

DME MAC Jurisdiction A Resource

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

December 2009
Number 14

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.: **http://www.medicarenhic.com/dme/**
- TriCenturion: **http://www.tricenturion.com**
- CMS: **http://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.
An HP Enterprise Services Company
A CMS Contractor

75 Sgt. William B. Terry Drive
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