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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June 2009
Number 12

Billing and 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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MOB Mobility/Support Surfaces	**PEN** Parenteral/Enteral Nutrition	

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

Instructions for Utilizing 837 Professional Claim Adjustment (CAS) Segments for Medicare Secondary Payer (MSP) Part B Claims (MM6211) (GEN)

MLN Matters® Number: MM6211 - Revised
Related CR Release Date: December 12, 2008
Related CR Transmittal #: R62MSP
Related Change Request (CR) #: 6211
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

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

Note: *This article was rescinded on March 27, 2009, when the related CR 6211 was rescinded. CR 6211 was replaced by CR 6427, which may be found at* ***http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf*** *on the CMS Web site. The related MLN Matters® article may be found at* ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6427.pdf*** *on the CMS Web site.*

Instructions for Utilizing 837 Professional Claim Adjustment Segments (CAS) for Medicare Secondary Payer (MSP) Part B Claims (This CR rescinds and fully replaces CR6211) (MM6427) (GEN)

MLN Matters® Number: MM6427
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R67MSP
Related Change Request (CR) #: 6427
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 6427 which informs Medicare contractors about the changes necessary to derive Medicare Secondary Payer (MSP) payment calculations from incoming 837 4010-A1 claims transactions.

What You Need to Know
CR 6427 is limited to providers billing Part B contractors (carriers and MACs) and DME MACs.

What You Need to Do
Include your CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which explains why the claim's billed amount was not fully paid.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions, and the implementation guides for each transaction are available at **http://www.wpc-edi.com** on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6427 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements,
- Physician and suppliers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 professional claim.

Adjustments made by the payer are reported in the CAS on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: *If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to accept as payment in full adjustment (OTAF). Details of the MSP provisions may be found in the CMS Internet Only Manuals 100-05 and in the federal regulations at 42 CFR 411.32 and 411.33. Physician and suppliers should no longer identify the OTAF in the CN1 segment of the 837.*

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 (CR6427) issued to your Medicare contractor is available at **http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf** on the CMS Web site.

July 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6471) (DRU)

MLN Matters® Number: MM6471
Related CR Release Date: May 15, 2009
Related CR Transmittal #: R1737
Related Change Request (CR) #: 6471
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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.

What You Need to Know
This article is based on Change Request (CR) 6471 and instructs Medicare contractors to download and implement the July 2009 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised

April 2009, January 2009, October 2008 and July 2008, files. They will use the July 2009 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 July 6, 2009 with dates of service July 1, 2009, through September 30, 2009.

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.

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

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

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

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

As appropriate, a unique Healthcare Common Procedure Coding System (HCPCS) code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of NOC HCPCS codes.

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

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

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5%. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4%. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106% of the ASP. CMS will update the payment allowance limits quarterly. There are exceptions to this general rule and they are stated in the *Medicare Claims Processing Manual*, Chapter 17, Section 20.1.3 and may be reviewed at **http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf** on the CMS Web site.

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

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

Use of Quarterly Payment Files
The following table shows how the quarterly payment files will be applied:

Payment Allowance Limit Revision Date	Applicable Dates of Service
July 2009 ASP and ASP NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008
July 2008 ASP and NOC files	July 1, 2008, through September 30, 2008

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

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 (CR6471) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1737CP.pdf** on the CMS Web site.

New Common Working File (CWF) Medicare Secondary Payer (MSP) Type for Workers' Compensation Medicare Set-aside Arrangements (WCMSAs), to Stop Conditional Payments (MM5371) (GEN)

MLN Matters® Number: MM5371 - Revised
Related CR Release Date: March 20, 2009
Related CR Transmittal #s: R1703CP, 65MSP
Related Change Request (CR) #: 5371
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Note: *This article was revised on March 20, 2009, to reflect a revised transmittal related to CR 5371. The CR was changed to clarify some of the requirements. The CR release date, transmittal numbers (see above), and the Web address for accessing that transmittal were changed. All other information remains the same.*

Provider Types Affected
Physician, providers and suppliers who bill Medicare contractors (carriers, including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs)) for services related to workers' compensation liability claims

What You Need to Know
In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), CR 5371, from which this article is taken, provides your Medicare contractors with instructions on the creation of a new MSP code in Medicare's claims processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) will have the capability to discontinue conditional payments for diagnosis codes related to such settlements.

Background
A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare. The CMS has

a review process for proposed WCMSA amounts and updates its CWF system in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit **http://www.cms.hhs.gov/WorkersCompAgencyServices** on the CMS Web site.

The CMS has determined that establishing a new MSP code in its systems, which identifies situations where CMS has reviewed a proposed WCMSA amount, will assist Medicare contractors in denying payment for items or services that should be paid out of an individual's WCMSA funds. The creation of a new MSP code specifically associated with the WCMSA situation will permit Medicare to generate an automated denial of diagnosis codes associated with the open WCMSA occurrence.

When denying a claim because of these edits, your Medicare contractor will notify the beneficiary using Medicare Summary Notice (MSN) message 29.33 - *Your claim has been denied by Medicare because you may have funds set aside from your settlement to pay for your future medical expenses and prescription drug treatment related to your injury(ies).*

In addition, Medicare will use Reason Code 201, Group Code PR, and Remark Code MA01, on outbound claims and/or remittance advice transactions when Medicare denies claims based on the WCMSA presence. Also, on 271 inquiry reply transactions, Medicare will reflect the WCMSA on the 271 response with "EB" followed by the qualifier WC.

Additional Information
You can find the official instruction (CR 5371) issued to your Medicare contractor in two transmittals:
http://www.cms.hhs.gov/Transmittals/downloads/R1703CP.pdf, and
http://www.cms.hhs.gov/Transmittals/downloads/R65MSP.pdf on the CMS Web site.

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

Training Medicare Patients on Use of Home Glucose Monitors and Related Billing Information (SE0905) (SPE)

MLN Matters® Number: SE0905
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians, providers, suppliers, and other healthcare professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Medicare-covered diabetes self management training (DSMT) benefits.

Provider Action Needed
This Special Edition article is being provided to help clarify the physician's role in prescribing and/or providing blood glucose self-testing equipment and supplies and diabetes self-management training (DSMT) covered for Medicare Beneficiaries with diabetes. The article reminds providers and suppliers about who may bill for DSMT and gives an overview of this benefit.

Background
Diabetes is the sixth leading cause of death in the United States, and approximately 23.6 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. This special edition article presents an overview of diabetes supplies and self-management training covered by Medicare.

Diabetes Self-Management Training (DSMT)
The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of diabetes DSMT services when these services are furnished by a certified provider who meets certain quality standards. The DSMT program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet

and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Diabetes self-management training services may be covered by Medicare only if the treating physician or treating qualified non-physician practitioner who is managing the beneficiary's diabetic condition certifies that such services are needed. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed as well as the following:

- The number of initial or follow-up hours ordered (the physician can order less than 10 hours of training);
- The topics to be covered in training (initial training hours can be used for the full initial training program or specific areas such as nutrition or insulin training); and
- A determination that the beneficiary should receive individual or group training.

The provider of the service must maintain documentation in a file that includes the original order from the physician and any special conditions noted by the physician. When the training under the order is changed, the training order/referral must be signed by the physician or qualified non-physician practitioner treating the beneficiary and maintained in the beneficiary's file in the DSMT's program records.

Initial Training

The initial year for DSMT is the 12 month period following the initial date, and Medicare will cover initial training that meets the following conditions:

- DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109;
- DSMT is furnished within a continuous 12-month period;
- DSMT does not exceed a total of 10 hours (the 10 hours of training can be done in any combination of 1/2 hour increments);
- With the exception of 1 hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries; and
- The one hour of individual training may be used for any part of the training including insulin training.

Follow-Up Training

Medicare covers follow-up training under the following conditions:

- No more than two hours individual or group training is provided per beneficiary per year;
- Group training consists of 2 to 20 individuals who need not all be Medicare beneficiaries;
- Follow-up training for subsequent years is based on a 12 month calendar after completion of the full 10 hours of initial training;
- Follow-up training is furnished in increments of no less than one-half hour; and
- The physician (or qualified non-physician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

NOTE: *All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.*

Certified Providers of DSMT

A designated certified provider bills for DSMT provided by an accredited DSMT program. Certified providers must submit a copy of their accreditation certificate to their Medicare contractor. The statute states that a "certified provider" is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under title XVIII, and meets certain quality standards. CMS has designated all providers and suppliers that bill Medicare for other individual services such as hospital outpatient departments, renal dialysis facilities, physicians and durable medical equipment suppliers as certified. All suppliers/providers who may bill for other Medicare services or items and who represent a DSMT program that is accredited as meeting quality standards can bill and receive payment for the entire DSMT program. Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service.

Coding and Payment of DSMT Services
The following Healthcare Common Procedure Coding System (HCPCS) codes should be used for DSMT:

- G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes; and
- G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.

Additional Information
See the *Medicare Benefits Policy Manual* (Chapter 15, Section 300) at **http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf** for complete details on Medicare's policy for DSMT.

See the *Medicare Claims Processing Manual* (Chapter 18, Section 120.1 (Coding and Payment of DSMT Services)) at **http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf** for detailed billing instructions for DSMT.

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.

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**. The following notices have been posted:

The following Fee Schedules have been added:

- April 2009 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2009 Oral Anticancer Drug Fees

The following Fee Schedules have been revised:

- January 2009 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- April 2008 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2009 Oral Anticancer Drug Fees

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

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

All existing DMEPOS suppliers subject to the bonding requirement must submit a copy of the required surety bond to the NSC no later than October 02, 2009.
(MM6392)

An Introductory Overview of the HIPAA 5010 (SE0904) (GEN)

MLN Matters® Number: SE0904
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All physicians, providers, and suppliers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries

What You Need to Know
Impact to You
The implementation of HIPAA 5010 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. **The implementation will require changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. So it is extremely important that you are aware of these HIPAA changes and plan for their implementation.**

What You Need to Know
The Administrative Simplification Act (ASCA) requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. **Therefore, effective January 1, 2012, you must be ready to submit your claims electronically using the X12 Version 5010 and NCPDP Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes.** The Centers for Medicare & Medicaid Services (CMS) will provide additional information to assist you and keep you apprised of progress on Medicare's implementation of HIPAA 5010 through a variety of communication vehicles. **Remember that the HIPAA standards, including the X12 Version 5010 and Version D.0 standards, are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare expects to begin transitioning to the new formats January 1, 2011 and ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate *MLN Matters*® articles will address the ICD-10 implementation.**

What You Need to Do
In preparing for the implementation of these new X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others. The Transactions and Code Sets final rule published on Aug. 17, 2000, adopted standards for the statutorily identified transactions, some of which were modified in a subsequent final rule published on Feb. 20, 2003.

These current versions of the standards (the Accredited Standards Committee X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. On January 16, 2009, HHS announced a final rule that replaces the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively.

Over 99 per cent of Medicare Part A claims and over 95 per cent of Medicare Part B claims transactions are received electronically and it is imperative that providers be ready for these new standards in order to continue submitting claims electronically. The remainder of this article will provide some rationale for the new standards and also provide some guidance to providers on preparing for this implementation.

Version 5010 (Health Care Transactions)
Version 5010 of the HIPAA standards includes improvements in structural, front matter, technical, and data content (such as improved eligibility responses and better search options). It is more specific in requiring the data that is needed, collected, and transmitted in a

transaction (such as tightened, clear situational rules, and in misunderstood areas such as corrections and reversals, refund processing, and recoupments). Further, the new claims transaction standard contains significant improvements for the reporting of clinical data, enabling the reporting of ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes, and distinguishes between principal diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes. These distinctions will improve the understanding of clinical data and enable better monitoring of mortality rates for certain illnesses, outcomes for specific treatment options, and hospital length of stay for certain conditions, as well as the clinical reasons for why the patient sought hospital care.

Finally, Version 5010 also addresses a variety of currently unmet business needs, including an indicator on institutional claims for conditions that were "present on admission," and accommodating the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1.

Version D.0 (Pharmacy Claims)
Version D.0 specifically addresses business needs that have evolved with the implementation of the Medicare prescription drug benefit (Part D) as well as changes within the health care industry. New data elements and rejection codes in Version D.0 will facilitate both coordination of benefits claims processing and Medicare Part D claims processing.

In addition, Version D.0:

- Provides more complete eligibility information for Medicare Part D and other insurance coverage;
- Better identifies patient responsibility, benefits stages, and coverage gaps on secondary claims; and
- Facilitates the billing of multiple ingredients in processing claims for compounded drugs.

The 5010/D.0 rule also adopts a standard for the Medicaid pharmacy subrogation transaction(known as NCPDP Version 3.0), as currently one does not exist for this process by which State Medicaid agencies recoup funds for payments they have made for pharmacy services for Medicaid recipients, when a third party payer has primary financial responsibility. Since many States presently conduct this transaction electronically, and employ a variety of standards with different payers, adoption of a standard for this transaction will increase efficiencies and reduce costs for Medicaid programs.

The compliance date for implementing Version 5010 and Version D.0 is January 1, 2012, to allow time to test the standards internally, to ensure that systems have been appropriately updated, and then to transition to the new formats between trading partners before the compliance date. For the Medicaid pharmacy subrogation standard, the compliance date is also January 1, 2012, except for small health plans, which must be compliant on January 1, 2013.

CMS Progress in Implementing the New Standards
CMS is well into the process of readying its FFS Medicare systems to handle the 5010/D.0 standards. All Medicare systems will be ready to handle the new standards by January 1, 2011. Medicare plans for its systems to handle the current 4010A standard and the new 5010/D.0 standards for incoming claims and inquiries and for outgoing replies and remittances from January 1, 2011 until January 1, 2012. This will allow providers who are ready to begin using the new standards on January 1, 2011, while providing an additional year for all providers to be ready.

In addition, where possible, CMS will be making system enhancements concurrent with the 5010/D.0 changes. These enhancements include capabilities such as:

- Implementing standard acknowledgement and rejection transactions across all jurisdictions (TA1, 999 and 277CA transactions);
- Improving claims receipt, control, and balancing procedures;
- Increasing consistency of claims editing and error handling;
- Returning claims needing correction earlier in the process; and
- Assigning claim numbers closer to the time of receipt.

Additional Information
You can find more information about HIPAA 5010 by going to **http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp** on the Electronic Billing & EDI Transactions page on the CMS Web site. Medicare has prepared a comparison of the current X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010 and the NCPDP EDI standards Version 5.1 to D.0, and has made these side-by-side comparisons available at this Web site. These comparisons may be of interest to other covered entities and their business associates.

A special edition *MLN Matters*® article on the ICD-10 code set is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf** on the CMS Web site.

CMS will also use the Open Door Forums and listservs as means of keeping providers informed of its implementation progress and will also use the vehicles to assist providers in getting ready for the new standards. Information on the Open Door Forums is available at **http://www.cms.hhs.gov/OpenDoorForums/** on the CMS Web site. Information about listservs (email updates) is available at **http://www.cms.hhs.gov/AboutWebsite/EmailUpdates/** on that same site.

In addition, a fact sheet on HIPAA 5010 is available at **http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3246&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date** on the CMS Web site. Finally, you can read the proposed rule in the *Federal Register*, Vol. 73, No. 164, Friday, August 22, 2008 at **http://edocket.access.gpo.gov/2008/pdf/E8-19296.pdf**; and the final rule in the *Federal Register*, Vol. 74, No. 11, Friday, January 16, 2009, at **http://edocket.access.gpo.gov/2009/pdf/E9-740.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.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (CR6453) (GEN)

Effective July 01, 2009 Change Request (CR) 6453 announces the release of the Remittance Advice and Claim Adjustment Reason Code updates. The complete list of reason codes is available from Washington Publishing, visit their Web site at: **http://www.wpc-edi.com/codes**

For information on the new codes, modified codes, and deactivated codes that are involved in this update, you can review CR6453 at: **http://www.cms.hhs.gov/transmittals/downloads/R1734CP.pdf**

Note: *The code update file must be downloaded to be used in conjunction with the updated MREP software.*

If you have any further questions regarding the reason code updates you can contact Customer Service at: 866-590-6731

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (MM6453) (GEN)

MLN Matters® Number: MM6453
Related CR Release Date: May 15, 2009
Related CR Transmittal #: R1734
Related Change Request (CR) #: 6453
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected
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 6453, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective July 1, 2009. Be sure billing staff are aware of these changes.

Background
The reason and remark code sets are 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. The CARC list is also updated 3 times a year - in early March, July, and November along with the RARC list.

Both code lists are posted at **http://www.wpc-edi.com/Codes** on the Internet. The lists at the end of the Additional Information section of this article summarize the latest changes to these lists, as announced in CR 6453.

CMS has also developed a tool to help you search for a specific category of remark code and that tool is available at **http://www.cmsremarkcodes.info** on the Internet. Note that this Web site does not replace the Washington Publishing Company (WPC) site. That site is **http://www.wpc-edi.com/Codes** and, should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional Information
As a reminder, CR 6336 noted that CARC 17 is being replaced with 2 new CARCs:

- 226: Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

- 227: Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

To see the official instruction (CR6453) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1734CP.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
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR.	1/25/2009
230	No available or correlating CPT/HCPCS code to describe this service, Note: Used only by Property and Casualty	1/25/2009

Modified Codes - CARC:

Code	Current Narrative	Effective Date per WPC Posting
187	Health Savings account payments. This change to be effective 10/1/2009: Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	1/25/2009

Deactivated Codes - CARC:

Code	Current Narrative	Effective Date
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	7/1/2009
156	Flexible spending account payments. Note: Use code 187	10/1/2009

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N516	Records indicate a mismatch between the submitted NPI and EIN.	NO
N517	Resubmit a new claim with the requested information	YES
N518	No separate payment for accessories when furnished for use with oxygen equipment.	YES

Modified Codes - RARC:

Code	Current Narrative	Medicare Initiated
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Start: 01/01/1997 Last Modified: 03/01/2009 Notes: (Modified 4/1/07. 3/1/2009)	YES
N109	This claim/service was chosen for complex review and was denied after reviewing the medical records. Start: 02/28/2002 | Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	YES
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. Start: 04/01/2007 | Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	YES

Deactivated Codes - RARC:

Code	Current Narrative	Medicare Initiated
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead) Start: 11/01/2008 | Stop: 10/01/2009	YES

Clarification about the Medical Privacy of Protected Health Information (SE0726) (GEN)

MLN Matters® Number: SE0726 - 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 May 11, 2009, to reflect updated Web addresses for several products referenced in the article.*

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, durable medical equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
The purpose of this Special Edition (SE) article, SE0726, is be sure that heath care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the Privacy Rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

HHS Privacy Guidance
HHS' educational materials include a letter to healthcare providers with the following examples to clarify the Privacy Rule:

HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:
Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) by searching the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at **http://www.hhs.gov/hipaafaq/** on the HHS Web site.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at **http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html** on the HHS Web site.
- Review the "Summary of the HIPAA Privacy Rule" at **http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html** on the HHS Web site.

HIPAA does not require providers to eliminate all incidental disclosures:

- The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that Rule to clarify that incidental disclosures do not violate the Privacy Rule when providers and other covered entities have policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.

- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR Web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the Fact Sheet on "Incidental Disclosures". The fact sheet is at **http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html** on the HHS Web site.

HIPAA does not cut off all communications between providers and the families and friends of patients:

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.

- The Privacy Rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.

- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.

- Review the provider's guide on communications with a patient's family, etc. at **http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf** on the HHS Web site.

HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.

- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.

- See the FAQs in the "Facility Directories" at **http://www.hhs.gov/ocr/privacy/hipaa/faq/administrative/485.html** on the HHS Web site.

HIPAA does not prevent child abuse reporting:
Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which can be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that can be reviewed at **http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html** on the HHS Web site.

HIPAA is not anti-electronic:
Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic can be found at **http://www.hhs.gov/hipaafaq/providers/smaller/482.html** on the HHS Web site.

Additional Information
The HHS complete listing of all HIPAA medical privacy resources is available at **http://www.hhs.gov/ocr/hipaa/** on the HHS Web site.

Discontinuance of the Unique Physician Identification Number (UPIN) Registry (MM5584) (GEN)

MLN Matters® Number: MM5584 - Revised
Related CR Release Date: September 14, 2007
Related CR Transmittal #: R222PI
Related Change Request (CR) #: 5584
Effective Date: May 29, 2007
Implementation Date: June 29, 2007

Note: *This article was revised on June 1, 2009, to remove the Web link to the UPIN registry, which is no longer maintained, and also to remove another link to the NPI contingency plan that no longer works as the information is no longer available on the Internet.*

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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 5584, which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

What You Need to Know
The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.)

What You Need to Do
If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) Web site at **https://nppes.cms.hhs.gov/** on the CMS Web site. See the Background and Additional Information Sections of this article for further details.

Background
The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007 implementation by Medicare.

The CMS discontinued assigning UPINs on June 29, 2007. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the Federal Register on May 30, 2007. This Notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

Additional Information
For additional information regarding NPI requirements and use, please see *MLN Matters*® articles, MM4023 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf**) titled, "*Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms*", and MM4293 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf**) titled, "*Revised CMS-1500 Claim Form*", which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the National Provider Identifier (NPI) and renamed CMS-1500 (08-05).

The official instruction, CR5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf** on the CMS Web site.

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

DMEPOS Supplier Accreditation - Time is Running Out - Deadline is September 30, 2009 (CMS Message 2009-02-23) (GEN)

Time is running out for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B to obtain accreditation by the **September 30, 2009** deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. A new *MLN Matters*® Special Edition article on this subject is now available. This article outlines what you need to do if you have not yet complied with the Medicare Program's supplier and quality standards to become accredited. To view the article on the CMS Web site, go to: **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0903.pdf**

While the accreditation process takes on average 6-7 months to complete, the process could take as long as 9 months to complete. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

In order to retain or obtain a Medicare Part B billing number, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary) must comply with the Medicare program's supplier standards and quality standards to become accredited. The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, and prosthetics and orthotics.

Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers **must also meet the September 30, 2009** deadline for DMEPOS accreditation. Certain eligible professionals and other persons as specified by the Secretary are exempt from the accreditation requirement.

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 the CMS Web site:
http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp

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Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Supplier Accreditation Requirements (SE0903) (GEN)

MLN Matters® Number: SE0903 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: March 1, 2009
Implementation Date: N/A

Note: *This article was revised on May 20, 2009, to provide important information for suppliers who choose not to become accredited.*

Provider Types Affected
All suppliers that furnish Medicare Part B durable medical equipment (DME), prosthetic devices, prosthetic or orthotic items, and supplies to Medicare beneficiaries.

Provider Action Needed
Impact to You
DMEPOS suppliers enrolled with the National Supplier Clearinghouse (NSC) are required to obtain accreditation by **September 30, 2009**.

What You Need to Know if You Choose Not to Become Accredited
In order to obtain or retain your Medicare Part B billing privileges, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary of the Department of Health and Human Services as noted below in this article) must comply with the Medicare program's supplier standards and quality standards and become accredited. These standards can be found in 42 CFR 424.57 or on page 36 & 37 of the CMS 855S. A DMEPOS supplier's Medicare Part B billing privileges will be revoked on or after

October 1, 2009, if the DMEPOS supplier fails to obtain accreditation unless the DMEPOS supplier submits a voluntary termination to the NSC by **September 30, 2009**.

What You Need to Do if You Choose Not to Become Accredited

For those DMEPOS suppliers who choose not to become accredited at this time, they will need to submit an amended CMS-855S application which reflects their voluntary termination. This will prevent the supplier from being revoked and subsequently barred from the Medicare program, as cited in 42 CFR Section 424.535(c). For pharmacies that choose not to become accredited but wish to remain a DMEPOS supplier in order to continue to bill Medicare for drugs and biologicals only, an amended CMS 855S will have to be completed. In addition to updating their application, the supplier must ensure that they have checked the appropriate boxes in Section 2 (C) to reflect which drugs and biologicals they will provide to beneficiaries. Providers and suppliers can find the latest version of CMS 855S at **http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a) (20) to the Social Security Act (the Act) that required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to obtain or retain their provider or supplier billing privileges.

Covered Items and Services

Pursuant to subparagraph 1834(a) (20) (D) of the Act, the covered items and services are defined in Section 1834 (a) (13), Section 1834 (h) (4) and Section 1842 (s) (2) of the Act. The covered items and services include:

- Durable Medical Equipment (DME);
- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Blood products;
- Transfusion medicine;
- Prosthetic devices, and
- Prosthetics and orthotics.

Non-Covered Items include:

- Medical supplies furnished by Home Health Agencies;
- Drugs used with DME (inhalation drugs and drugs infused with a DME pump);
- Implantable items and;
- Other Part B drugs:
  - Immunosuppressive drugs and
  - Anti-emetic drugs.

DMEPOS Quality Standards

The quality standards are published at
http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DMEPOSAccreditationStandards.pdf
on the CMS Web site, are separated into two sections and have three appendices as follows:

- **Section I** includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management, product safety and information management.

- **Section II** contains service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver and follow-up service.

- **Appendix A** addresses respiratory equipment, supplies and services.

- **Appendix B** addresses manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.

- **Appendix C** addresses custom fabricated and custom fitted orthoses, prosthetic devices, external breast prostheses, therapeutic shoes and inserts and their accessories and supplies, and custom-made somatic, ocular and facial prostheses.

Accreditation Deadline for DMEPOS Suppliers
The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) set a deadline for all DMEPOS suppliers to be accredited by September 30, 2009.

Who Needs Accreditation?
The September 30, 2009, accreditation deadline applies to all suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics and orthotics that are enrolled with the NSC. The accreditation deadline also applies to pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians and athletic trainers.

Who is Exempt?
The eligible professionals that are exempt from the September 30, 2009, accreditation deadline include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act);
- Physician Assistants;
- Nurse Practitioners;
- Physical Therapists;
- Occupational Therapists;
- Speech-Language Pathologists;
- Clinical Nurse Specialists;
- Certified Registered Nurse Anesthetists;
- Certified Nurse-Midwives;
- Clinical Social Workers;
- Clinical Psychologists;
- Registered Dietitians; and
- Nutritional professionals.

Additionally MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the September 30, 2009, accreditation deadline unless the Secretary determines that the quality standards are specifically designed to apply to such other persons. At this time, these "other persons" are only defined as the following practitioners:

- Orthotists;
- Prosthetists;
- Opticians; and
- Audiologists.

Key Points
All Medicare Part B enrolled DMEPOS providers and suppliers are required to obtain accreditation by **September 30, 2009**.

DMEPOS suppliers who submitted a completed application to an accrediting organization on or before January 31, 2009, ***will have their accreditation decision*** *(either full accreditation or denied accreditation) on or before the September 30, 2009, deadline.*

DMEPOS suppliers submitting applications to an accrediting organization after January 31, 2009, ***may or may not have their accreditation decision*** *by the September 30, 2009, deadline.*

A DMEPOS supplier's Medicare Part B billing privileges will be revoked on or after October 1, 2009, if the DMEPOS supplier fails to obtain accreditation or a voluntary termination has not been received by the NSC by September 30, 2009. If a supplier chooses not to become accredited, they must submit an amended CMS 855S to prevent revocation and subsequent exclusion from the Medicare program.

Accreditation Frequently Asked Questions (FAQs)
1. Do the accrediting organizations have enough capacity to get everyone who applies at least 9 months before September 30, 2009 accredited by the deadline?

Yes. The AO's have increased surveyor staffing anticipating the additional workload. A DMEPOS supplier should choose an AO based upon their deemed status, policies, procedures and the philosophy of the organization. CMS encourages suppliers to ask the AO's questions, such as, how long it takes to become accredited from application to accreditation decision. The time to become accredited can take up to 9 months for some organizations.

2. Who are the approved DMEPOS accrediting organizations?
In November 2006, CMS approved (deemed) 10 national accreditation organizations that will accredit providers and suppliers of DMEPOS as meeting new quality standards under Medicare Part B. Most of the accreditation organizations are authorized to accredit all major supplier types, and most will be able to accredit both national and local suppliers, as well as mail order companies. A list of the CMS approved deemed accreditation organizations and information about the types of suppliers each accrediting organization is approved to accredit and how to contact a deemed accrediting organization is posted at:
http://www.cms.hhs.gov/MedicareProviderSupEnroll/Downloads/DeemedAccreditationOrganizations.pdf on the CMS Web site.

3. Is accreditation transferable upon merger, acquisition or sale of a supplier?
Accreditation cannot be transferred upon merger, acquisition or sale of a supplier. As specified in 42 CFR 424.57 (c) (3), CMS, the NSC and the accrediting organization must be notified when a new DMEPOS location is opened.

4. If I have just recently received a survey by an accreditor, will I be subject to a site visit by a representative of the National Supplier Clearinghouse (NSC)?
These actions are independent of one another. The accreditor checks quality standards. The NSC site visit concerns enforcing supplier standards. In many cases a new supplier will receive a site survey by the AO and a site visit by the NSC.

5. Is information transferred between the accreditor and NSC?
Transfer of information between these two entities concerning their findings does occur.

6. Will the accreditation survey efforts be coordinated with reenrollment efforts?
Not at the present time. A supplier must meet both the NSC supplier standards and the accreditation requirements on a continuous basis. We are not changing reenrollment dates and timeframes to match survey timeframes.

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. There is additional information on the accreditation process at
http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp on the CMS Web site.

GET READY FOR COMPETITIVE BIDDING! (CMS Message 2009-05-29) (GEN)

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, made limited changes to the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, including a requirement that competition to re-bid Round 1 occur in 2009. On January 16, 2009, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period that incorporates into regulations only those provisions of MIPPA related to the DMEPOS competitive bidding program that are self-implementing and necessary to conduct the Round 1 rebid competition in 2009. That rule became effective on April 18, 2009. To ensure that suppliers have ample time to prepare for the competition, CMS has announced the following next steps for the program:

SPRING 2009
- CMS BEGINS PRE-BIDDING SUPPLIER AWARENESS CAMPAIGN
- PROGRAM ADVISORY AND OVERSIGHT COMMITTEE (PAOC) MEETING (JUNE 4, 2009)

SUMMER 2009
- CMS ANNOUNCES BIDDING SCHEDULE/SCHEDULE OF EDUCATION EVENTS
- CMS BEGINS BIDDER EDUCATION CAMPAIGN

- BIDDER REGISTRATION PERIOD TO OBTAIN USER IDS AND PASSWORDS BEGINS

FALL 2009

- BIDDING BEGINS

If you are a supplier interested in bidding, prepare now - don't wait!

- **UPDATE YOUR NSC FILES:** DMEPOS supplier standard # 2 requires ALL suppliers to notify the National Supplier Clearinghouse (NSC) of any change to the information provided on the Medicare enrollment application (CMS-855S) within 30 days of the change. DMEPOS suppliers should use the 3/09 version of the CMS-855S and should review and update:
  - The list of products and services found in section 2.D;
  - The Authorized Official(s) information in sections 6A and 15; and
  - The correspondence address in section 2A2 of the CMS-855S.

  This is especially important for suppliers who will be involved in the Medicare DMEPOS Competitive Bidding Program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program. Information and instructions on how to submit a change of information may be found on the NSC Web site (http://www.palmettogba.com/nsc) and by following this path: Supplier Enrollment / Change of Information / Change of Information Guide.

- **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 NSC. As part of the bid evaluation we will verify with the NSC that the supplier has on file a copy of all applicable required state license(s).

- **GET ACCREDITED:** CMS would like to remind DMEPOS suppliers again that time is running out to obtain accreditation by the September 30, 2009 deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. Accreditation takes an average of 6 months to complete. It is very important for DMEPOS suppliers to contact an accreditation organization right away to obtain information about the accreditation process and submit an application. Suppliers must be accredited for a product category in order to submit a bid for that product category. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

  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 the CMS Web site: **http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp**

- **GET BONDED:** CMS would like to remind DMEPOS suppliers that certain suppliers will need to obtain and submit a surety bond by the October 2, 2009 deadline or risk having their Medicare Part B billing privileges revoked. Suppliers subject to the bonding requirement must be bonded in order to bid in the DMEPOS competitive bidding program. A list of sureties 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 .

Visit the CMS Web site at: **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/** for the latest information on the DMEPOS competitive bidding program.

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

Roll-out: Medicare Competitive Bidding Program for DMEPOS, Round One Rebid (CMS Message 2009-05-29) (GEN)

MEDICARE BEGINS SUPPLIER EDUCATION FOR THE COMPETITIVE BIDDING PROGRAM FOR CERTAIN MEDICAL EQUIPMENT AND SUPPLIES
Supplier Bid Window to Open in Fall 2009

The Centers for Medicare & Medicaid Services (CMS) today announced the next steps in the implementation of the Round One Rebid of the Medicare Competitive Bidding Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including the general timeline for opening the bid window in the fall of this year.

"Congress mandated that competition for the Round One Rebid occur in 2009. CMS is announcing the next steps to implement the DMEPOS Competitive Bidding Program now to give the supplier community ample time to prepare as well as inform other stakeholders," said Charlene Frizzera, CMS Acting Administrator. "This program generated substantial savings for Medicare and beneficiaries who used these items and supplies in the competitive bidding areas last summer and is consistent with CMS' goal to pay appropriately for Medicare items and services."

CMS will now begin general "pre-bidding" supplier awareness and education efforts on key steps suppliers need to take now to be ready for registration and bidding including getting appropriate State licenses, updating Medicare enrollment files with the National Supplier Clearinghouse and getting accredited and bonded. On June 4, 2009, CMS will convene a meeting of the DMEPOS competitive bidding Program Advisory and Oversight Committee (PAOC) before announcing the detailed timeline for the program in the summer. The bidder registration period is expected to begin this summer before bidding opens in the fall. CMS has made a number of process improvements for the Round One Rebid, such as an upgraded on-line bid submission system, early bidder education, and increased oversight of bidders that are new to product categories or competitive bidding areas to ensure they meet CMS' requirements.

As part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress enacted a temporary delay of the competitive bidding program and mandated certain changes in the program. The law required CMS to terminate contracts awarded in Round One and to conduct the competition for the Round One Rebid in 2009. Additionally, the new law establishes a financial document review process and a requirement for contract suppliers to report subcontract relationships with other suppliers. MIPPA also excluded certain DMEPOS items and areas from competitive bidding and provided an exemption to the program for hospitals that furnish certain types of DMEPOS items to their own patients. However, MIPPA did not fundamentally change the nature of the competitive bidding program as established by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) or the existing competitive bidding regulations that were finalized in 2007.

From a beneficiary standpoint, there will be no immediate effect on the Medicare DMEPOS benefit and Medicare beneficiaries may continue to use their current DMEPOS suppliers at this time.

Round One of the DMEPOS competitive bidding program was implemented on July 1, 2008, in 10 competitive bidding areas, as mandated by the MMA. The Round One competitive bidding process resulted in average savings of 26 percent compared to the prices Medicare would have paid for the competitive bid items under the existing DMEPOS fee schedule in 2008. These lower prices would have directly translated to lower out-of-pocket costs for Medicare beneficiaries, who are responsible for 20 percent coinsurance on these items and services after any unmet Part B deductible.

The DMEPOS competitive bidding program, combined with Medicare's accreditation and quality standard efforts, will help to assure that high quality service and items continue to be available to beneficiaries who need medical equipment and supplies.

Additional information on the DMEPOS competitive bidding program is available at:
http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp#TopOfPage

The CMS press release issued today is available at:
https://www.cms.hhs.gov/apps/media/press_releases.asp

The CMS fact sheet issued today is available at:
https://www.cms.hhs.gov/apps/media/fact_sheets.asp

Surety Bonds for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (MM6392) (GEN)

MLN Matters® Number: MM6392
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R287PI

Related Change Request (CR) #: 6392
Effective Date: April 6, 2009
Implementation Date: April 6, 2009

Provider Types Affected
Suppliers submitting claims to Medicare DME Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6392. The Centers for Medicare & Medicaid Services (CMS), via the *Medicare Program Integrity Manual*, Chapter 10, alerts **certain DMEPOS suppliers that they need to obtain a surety bond as a prerequisite for enrolling and maintaining enrollment in the Medicare program**. Be sure you are familiar with and in compliance with Medicare's surety bond requirements as summarized in this article and as detailed in CR 6392.

Background
Effective May 4, 2009, DMEPOS suppliers submitting: (1) an initial enrollment application to enroll in the Medicare program for the first time, (2) an initial application to establish a new practice location, or (3) an enrollment application to change the ownership of an existing supplier, are required to obtain and submit a copy of its required surety bond to the NSC with their CMS-855S enrollment application.

All existing DMEPOS suppliers subject to the bonding requirement must submit a copy of the required surety bond to the NSC no later than October 2, 2009.

Exceptions
All DMEPOS suppliers are subject to the surety bond requirement, except:

- Government-operated DMEPOS suppliers are exempted if the supplier has provided CMS with a comparable surety bond under State law. (All Indian Health Service (IHS) facilities that are not wholly owned and operated by a tribe are exempt.)

- State-licensed orthotic and prosthetic personnel (which, for purposes of the surety bond requirement, does not include pedorthists) in private practice making custom- made orthotics and prosthetics are exempted if -
  - The business is solely-owned and operated by the orthotic and prosthetic personnel, and
  - The business is only billing for orthotic, prosthetics, and supplies.

- Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act, are exempted if the items are furnished only to the physician or non-physician practitioner's own patients as part of his or her physician service. The non-physicians covered under this exception are: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

- Physical and occupational therapists in private practice are exempted if -
  - The business is solely-owned and operated by the physical or occupational therapist;
  - The items are furnished only to the physical or occupational therapist's own patients as part of his or her professional service; and
  - The business is only billing for orthotics, prosthetics, and supplies.

Amount and Basis of the Surety Bond
The surety bond must be in an amount of no less than $50,000 per National Provider Identifier (NPI). Since DMEPOS suppliers must obtain an NPI by practice location, except for sole proprietorships, an organizational DMEPOS supplier with 10 locations would be required to secure a $500,000 surety bond.

Suppliers will be required to maintain an **additional** elevated surety bond amount of $50,000 **for each final adverse action** imposed against it within the 10 years preceding enrollment or reenrollment. This amount is in addition to, and not in lieu of, the base $50,000 amount that must be maintained.

A supplier may obtain a single bond that encompasses multiple locations. For instance, if a supplier has 10 separately-enrolled DMEPOS locations, it may obtain a $500,000 bond that covers all 10 locations. Likewise, if a supplier seeks to enroll a new location, it may submit to the NSC an amendment or rider to the existing bond, rather than a new, separate surety bond.

Bond Terms

Specific terms that the bond must contain include:

- A guarantee that the surety will - within 30 days of receiving written notice from CMS containing sufficient evidence to establish the surety's liability under the bond of unpaid claims, civil monetary penalties (CMPs), or assessments - pay CMS a total of up to the full penal amount of the bond in the following amounts:
  - The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible, and
  - The amount of any unpaid claims, CMPs, or assessments imposed by CMS or the OIG on the DMEPOS supplier, plus accrued interest.

- A statement that the surety is liable for unpaid claims, Civil Monetary Penalties (CMPs), or assessments that occur during the term of the bond;

- A statement that actions under the bond may be brought by CMS or by CMS contractors;

- The surety's name, street address or post office box number, city, state, and zip code; and

- Identification of the DMEPOS supplier as the Principal, CMS as the Obligee, and the surety (and its heirs, executors, administrators, successors and assignees, jointly and severally) as the surety.

A copy of the bond agreement, as well as any certificates of proof, must be submitted.

Sureties

The list of sureties from which a bond can be secured is found at the Department of the Treasury's "Listing of Certified (Surety Bond) Companies" Web site at **http://www.fms.treas.gov/c570/c570_a-z.html** on the Internet. For purposes of the surety bond requirement, these sureties are considered "authorized".

Additional Information

If you have questions, please visit the National Supplier Clearinghouse's "Frequently Asked Questions" page at **http://www.palmettogba.com/PALMETTO/PALMETTO.NSF/DocsCat/Home**. (When you get to this page, click on the FAQ link, followed by the "National Supplier Clearinghouse" link.)

The official instruction (CR6392) issued to your Medicare DME MAC, is available at **http://www.cms.hhs.gov/Transmittals/downloads/R287PI.pdf** on the CMS Web site. Included with CR 6392 is the actual revision to Chapter 10 of the *Medicare Program Integrity Manual*, which has further details on the surety bond requirement.

Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries (MM6139) (GEN)

MLN Matters® Number: MM6139 - Revised
Related CR Release Date: March 4, 2009
Related CR Transmittal #: R25COM
Related Change Request (CR) #: 6139
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Note: *This article was revised on March 5, 2009, to reflect the revised CR 6139, which CMS re-issued on March 4, 2009. (The effective and implementation dates for providers were previously changed to April 6, 2009 by Transmittal R23COM on February 10.) In this revision of the article, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same.*

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

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

Effective April 6, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication: 1) Your National Provider Identifier (NPI); 2) Your Provider Transaction Access Number (PTAN); and 3) The last 5-digits of your tax identification number (TIN).

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

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

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

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

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

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

Authentication of Providers with No NPI
Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer

recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

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

Beneficiary Authentication
Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

1) Last name,
2) First name or initial,
3) Health Insurance Claim Number (HICN), and
4) Either date of birth (eligibility, next eligible date, Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim)) or date of service (claim status, CMN/DIF (post-claim)).

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

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

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

Additional Information
You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at **http://www.cms.hhs.gov/Transmittals/downloads/R25COM.pdf** on the CMS Web site.

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

Effective April 06, 2009, Your NPI, PTAN, and the last 5 digits of your TIN are now required for authentication when calling the IVR or Customer Service.

Important Information Regarding the Centers for Medicare & Medicaid Services (CMS) National Claims Crossover Process (SE0909) (GEN)

MLN Matters® Number: SE0909
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
All Medicare physicians, providers, and suppliers

Provider Action Needed
Physicians, providers, and suppliers should note that this special edition article is to request that they allow sufficient time for the Medicare crossover process before attempting to balance bill their patients' supplemental insurers and payers for amounts remaining after Medicare's payment determination on their submitted claims.

Background
The Centers for Medicare & Medicaid Services (CMS) consolidated the "automatic" or eligibility file-based crossover process under the Coordination of Benefits Contractor (COBC) as of September 2006. Under the "automatic" crossover process, other supplemental insurers, including Medicaid agencies, sign a standard national Coordination of Benefits Agreement (COBA) with the CMS contractor, the COBC. They then submit enrollment information via a standard eligibility file feed through a secure connection with the COBC. Within this eligibility feed, the supplemental insurers identify their covered members or policy/ certificate holders for Medicare claim matching purposes. The COBC, in turn, transmits this information to the CMS Common Working File (CWF). After the CMS CWF system tags individual claims for crossover to a designated insurer, it then prompts the Medicare contractor to send the adjudicated claims to the COBC for crossover purposes once the claims have met their payment floor requirements, as prescribed by CMS.

The CMS consolidated the Medigap claim-based crossover process under the COBC in October 2007. Under this process, the COBC assigns to a Medigap plan a 5-digit Medigap claim-based COBA ID (range 55000 through 59999) to ensure that if participating Part B physicians or suppliers enter that value on incoming paper CMS-1500 claim forms or 837 professional claims, the Medicare contractor will be able to transfer the claims to the COBC for crossover to that specific Medigap plan.

IMPORTANT: Virtually all Medigap insurers participate in the automatic or eligibility file-based crossover process. Approximately ten or eleven Medigap plans avail themselves of the less commonly used Medigap claim-based crossover process, which cannot be used in association with Part A 837 institutional claims (including inpatient, outpatient, home health, and hospice related types of bills) or with claims for which the physician or supplier is non-participating with Medicare. These insurers, some of whom also participate in part in the automatic crossover process, may be referenced at
http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf
on the CMS Web site.

Situations Where Balance Billing of Supplemental Insurers Is Justified

Situation 1: Claim Data Errors Encountered
Approximately 98 percent of all claims that Medicare indicates crossed-over, as annotated on its generated 835 electronic remittance advice (ERA) and standard paper remittance advice (SPR), actually were successfully transmitted to supplemental insurers. For the remaining two (2) percent of cases, the physician, provider, or supplier's claims fail Health Insurance Portability and Accountability Act (HIPAA) compliance within the COBC's code validation routine. In addition, due to Medicare's shared claims processing systems problems, Medicare contractors occasionally transmit structurally unusable claims to the COBC. Such claims are rejected back to the Medicare contractor within 24 hours of receipt. Finally, the COBC may, in some instances, successfully transmit claims to various supplemental insurers only to have them rejected due to issues such as national provider identifier (NPI) mismatch (dispute error code 200), claims selection criteria problems (dispute error code 600), and less frequently HIPAA compliance matters (dispute error code 700).

When the COBC rejects claims back to the Medicare contractors, they issue special correspondence letters (sent to your Medicare on-file "correspondence" address) to your organization within five (5) business days from COBC's rejection action. The special letters indicate the affected claims, including Health Insurance Claim Number (HICN) and associated internal control number (ICN)/document control number (DCN), along with an error code and error description specifying why the COBC could not cross-over the affected

claims. This same procedure occurs when insurers reject claims, typically several days later through a dispute process with the COBC, with the exception that standard verbiage is carried on the special letter indicating that the affected claim(s) was/were rejected by the supplemental insurer and an associated dispute error code appears (e.g., 200, 600, 700). When providers receive such notifications, they should then attempt to bill the supplemental insurer or benefit program, given that Medicare was unable to cross-over the affected claim(s) successfully.

Situation 2: Patient's Insurer Not Part of Crossover Process

If you can clearly determine that your patient's insurer cannot or will not voluntarily participate in the CMS national crossover process, you are, of course, within your rights to balance bill your patient's supplemental insurer.

A Special Note Regarding Claim Repair Processes

When a Medicare contractor's volume of HIPAA compliance rejections equals or exceeds four (4) percent of all claims that the affected Medicare contractor transmitted to the COBC for a given day, **or** if entire envelopes of claims fail structural editing at the COBC, that Medicare contractor is instructed by CMS to go into "claim repair mode." That is, the Medicare contractor is to do the following:

- Determine how long it will take, working through its shared claims processing system maintainer, to effectuate a correction of the errored claims; and
- Subject to concurrence from CMS, initiate a claim repair for all claims with a given error condition. Typically, most repairs are accomplished within 10 to 15 business days from the date when the COBC rejected the claims.

IMPORTANT: At CMS direction, most Medicare contractors, including Medicare Administrative Contractors (MACs), will alert you to such situations in the interests of ensuring that you do **not** balance bill your affected patients' supplemental insurers or benefit programs. In the majority of instances, Medicare contractors will issue the special correspondence letters, which have been held within the system, if they have determined through consultation with CMS that a claims repair cannot be accomplished. You may also receive additional information about the abandonment of a claims repair process via the affected Medicare contractors' provider Web site.

Requested Physician, Provider, and Supplier Action

Recently, CMS has received a growing number of complaints from supplemental insurers about their receipt of paper SPRs or printed 835 ERAs that physician, provider, and supplier billing vendors are generating well in advance of their receipt of the CMS "official" Medicare crossover claims. Consequently, these supplemental insurers are in receipt of duplicate claim pairings - one generated on paper by the provider and another, the "official" crossover claim, generated from the COBC.

Since payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued, CMS requests that you do not bill your patients' supplemental insurers for a minimum of 15 work days after receiving the Medicare payment.

This should allow sufficient time for any potential CMS-approved Medicare claims recovery situations should they need to occur and for the supplemental insurer to take actions necessary to issue payment determination following its receipt of a Medicare crossover claim. Additionally, CMS requests that physicians, providers, and suppliers take the following actions before balance billing their patients' supplemental insurers:

- Check the following CMS Web site for verification that your patient's supplemental insurer is participating in the automatic crossover process nationally with the CMS COBC: **http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf** on the CMS Web site. **Note:** As verified by the spreadsheet's header, this document is a listing of all participants in the Medicare automatic crossover process. It is not just a listing of beneficiary and provider contact information for each insurer indicated.

- Prior to submitting a claim to a supplemental payer/insurer, you should utilize available self-service tools to research the status of your supplemental payment (e.g., the supplemental insurer's Web site, or claims automated "hot line," as applicable).

In addition, as a reminder, only the "official" Medicare remittance advice or HIPAA 835 ERA should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status **not** be submitted to a supplemental payer/insurer for billing purposes even if:

- You are billing the supplemental payer/insurer after the 15 work days from the Medicare-issued payment have expired; and
- You have used the available self-service tools to confirm the status of your supplemental payment.

Additional Information
You may also want to review *MLN Matters*® article MM5601 (Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to the Coordination of Benefits Contractor (COBC)) at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf** on the CMS Web site.

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.

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

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

Note: *This article was revised on May 29, 2009, to include a Web link to CR6284, which was recently issued by CMS. All other information remains the same.*

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

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

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

Decision to implement would occur if:

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

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

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

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

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

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

Additional Information
Additional CMS influenza pandemic policy documents include:

- CR 6146, which can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R404OTN.pdf** on the CMS Web site;
- CR 6164, which can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R402OTN.pdf** on the CMS Web site;
- CR 6174, which can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R403OTN.pdf** on the CMS Web site;
- CR 6209, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R411OTN.pdf** on the CMS Web site;
- CR 6256, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R428OTN.pdf** on the CMS Web site;
- CR 6280, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R441OTN.pdf** on the CMS Web site;
- CR6284, which is at **http://www.cms.hhs.gov/Transmittals/downloads/R439OTN.pdf**; and
- CR 6378, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R454OTN.pdf** on the CMS Web site.

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

Mandatory Claims Submission and its Enforcement (SE0908) (GEN)

MLN Matters® Number: SE0908
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Physicians and suppliers submitting claims to Medicare contractors (carriers and/or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) is issuing this special edition article to remind physicians and suppliers of the Medicare requirements for mandatory electronic claims submission and its enforcement.

What You Need to Know
The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment.

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

Background
The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries, and the requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment. Compliance to mandatory claim filing requirements is monitored by CMS, and violations of the requirement may be subject to a civil monetary penalty of up to $2,000 for each violation, a 10 percent reduction of a physician's/supplier's payment once the physician/supplier is eventually

brought back into compliance, and/or Medicare program exclusion. Medicare beneficiaries may not be charged for preparing or filing a Medicare claim.

For the official requirements, see the following:

- Social Security Act (Section 1848(g)(4)(A); "Physician Submission of Claims") at **http://www.ssa.gov/OP_Home/ssact/title18/1848.htm** on the Internet.
- Requirement to file claims - The *Medicare Claims Processing Manual*, Chapter 1, Section 70.8.8: **http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf** on the CMS Web site.

Exceptions to Mandatory Filing

Physicians and suppliers are not required to file claims on behalf of Medicare beneficiaries for:

- Used Durable Medical Equipment (DME) purchased from a private source;
- Medicare Secondary Payer (MSP) claims when you do not possess all the information necessary to file a claim;
- Foreign claims (except in certain limited situations);
- Services furnished by opt out physicians or practitioners (except in emergency or urgent care situations when the opt out physician or practitioner has not previously entered into a private contract with the beneficiary);
- Services that are furnished for free; or
- Services paid under the indirect payment procedure.

For further details, see the *Medicare Claims Processing Manual* (Chapter 1, Section 70.8.8.8) at **http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf** on the CMS Web site.

Note: You are not required to file a claim for a service that is categorically excluded from coverage (e.g., cosmetic surgery, personal comfort services, etc; see 42 CFR 411.15 for details). However, many Medicare supplemental insurance policies pay for services that Medicare does not allow, and they may require a Medicare denial notice.

Beneficiary Submitted Claims

The current Medicare manual requirement instructs Medicare contractors (carriers and MACs) to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided. Medicare contractors are instructed to process beneficiary submitted claims for services that:

- **Are <u>not covered</u> by Medicare** (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details at **http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf** on the internet) in accordance with its normal processing procedures, and

- **Are <u>covered</u> by Medicare** when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S; see **http://www.cms.hhs.gov/CMSForms/CMSForms/** or **http://www.cms.hhs.gov/cmsforms/downloads/cms1490s-english.pdf** on the CMS Web site) and all supporting documentation associated with the claim, including an itemized bill with the following information:
  - Date of service,
  - Place of service,
  - Description of illness or injury,
  - Description of each surgical or medical service or supply furnished,
  - Charge for each service,
  - The doctor's or supplier's name, address, and
  - The provider or supplier's National Provider Identifier (NPI).

If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims when the beneficiary used Form CMS-1500 with instructions how to complete and return the appropriate beneficiary claims Form CMS-1490S for processing.

When manually returning a beneficiary submitted claim (Form CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:

- The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable); and
- In order to submit the claim, the provider must enroll in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:

- Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare; and
- Submit a complete Form CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the beneficiary's claim Form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

Additional Information
If you have any questions, please contact your carrier 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.

Modification of the Common Working File (CWF) Copybook to Transmit "WC" Qualifier Alpha Codes to Various Systems (supplement to CR 5371) (MM6438) (GEN)

MLN Matters® Number: MM6438
Related CR Release Date: May 1, 2009
Related CR Transmittal #: R487OTN
Related Change Request (CR) #: 6438
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Provider Types Affected
Physician, providers and suppliers who bill Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and Part A/B Medicare administrative contractors (A/B MACs)) for services related to workers' compensation liability claims.

Provider Action Needed
This article is based on Change Request (CR) 6438 and is informational only for providers. In order to prevent Medicare's paying primarily for future medical expenses that should be covered by workers' compensation Medicare set-aside arrangements (WCMSA), a prior instruction from Medicare, CR 5371, provided your Medicare contractors with instructions on the creation of a new Medicare Secondary Payer (MSP) code in Medicare's claims processing systems. With the creation of the new MSP code, the Centers for Medicare & Medicaid Services (CMS) has the capability to discontinue conditional payments for diagnosis codes related to WCMSA settlements.

Background
A WCMSA is an allocation of funds from a workers' compensation (WC) related settlement, judgment or award that is used to pay for an individual's future medical and/or future prescription drug treatment expenses related to a workers' compensation injury, illness or disease that would otherwise be reimbursable by Medicare. (The "WC" qualifier denotes a Workers' Compensation Medicare Set-aside Arrangement.) CMS has a review process for proposed WCMSA amounts and updates its systems in connection with its determination regarding the proposed WCMSA amount. For additional information regarding WCMSAs, visit **http://www.cms.hhs.gov/WorkersCompAgencyServices** on the CMS Web site.

Change Request (CR) 5371 added the qualifier of "WC" to distinguish a WCMSA Medicare Secondary Payer (MSP) Auxiliary Record from a WC MSP record. An *MLN Matters*® article related to CR 5371 is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5371.pdf** on the CMS Web site.

Even though the "WC" qualifier was added by CR 5371, no adjustment was made to allow for the transfer of the WC modifier's alpha codes from the CWF system to other important Medicare systems and CR 6438 will implement that transfer.

Additional Information
The official instruction, CR 6438, 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/R487OTN.pdf** on the CMS Web site.

Payment for Maintenance and Servicing of Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (MM6404) (GEN)

MLN Matters® Number: MM6404 - Rescinded
Related CR Release Date: March 20, 2009
Related CR Transmittal #: R461OTN
Related Change Request (CR) #: 6404
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Note: *This article was rescinded on May 27, 2009, and replaced by article number MM6509, which is at* ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6509.pdf*** *on the Centers for Medicare & Medicaid Services Web site. The article was rescinded because CR 6404 was rescinded and replaced by CR 6509.*

Payment for Maintenance and Servicing of Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 - CR 6509 RESCINDS AND FULLY REPLACES CR 6404 (MM6509) (OXY)

MLN Matters® Number: MM6509
Related CR Release Date: May 22, 2009
Related CR Transmittal #: R497OTN
Related Change Request (CR) #: 6509
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected
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 replacement change request (CR) 6509 which provides additional instructions regarding maintenance and servicing of oxygen concentrators and transfilling equipment resulting from implementation of section 144(b) of the MIPPA. Earlier instructions pertaining to the MIPPA changes for oxygen equipment were issued as part of CRs 6297 (Transmittal 421) and 6296 (Transmittal 443) and the *MLN Matters*® articles for these CRs are available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf** and **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf**, respectively, on the Centers for Medicare & Medicaid (CMS) Web site.

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 payment cap. Section 144(b) of MIPPA mandates payment for reasonable and necessary maintenance and servicing of oxygen equipment furnished after the 36-month rental cap. The 36-month cap applies to stationary and portable oxygen equipment furnished on or after January 1, 2006; therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006.

CMS has 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), and 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.

In the case of all oxygen equipment furnished after the 36-month rental cap, the supplier is responsible for performing any repairs or maintenance and servicing of the equipment that is necessary to ensure that the equipment is in good working order for the remainder of the reasonable useful lifetime for the equipment. This includes parts that must be replaced in order for the supplier-owned equipment to continue to function appropriately. Payment shall not be made for any repairs or maintenance and servicing, other than the maintenance and servicing payments described above, of oxygen equipment. Suppliers may not charge beneficiaries for any repairs, parts or servicing of equipment that they are required to furnish for the remainder of the equipment's reasonable useful lifetime.

Key Points

- Medicare contractors will pay claims with dates of service from July 1, 2009 thru December 31, 2009, 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 thru December 31, 2009, 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. HCPCS code K0738 must be billed with the HCPCS modifier "MS" to obtain such payment.

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

- If maintenance and servicing is billed for a column I code in the following table, additional payment for the maintenance and servicing of any of the column II codes should not be made as in the following example:

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 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.

- Program instructions will be issued in the future regarding the continuation of the maintenance and servicing payments for dates of service on or after January 1, 2010.

Additional Information

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

The official instruction, CR6509, issued to your Medicare DME MAC, MAC and/or RHHI regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R497OTN.pdf** on the CMS Web site.

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

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

Note: *This article was revised on May 19, 2009, to modify the description of the ICD-10-CM diagnoses codes on page 3 and to modify a Web address on page 4 to link to the ICD-10 Final Rule. All other information remains the same.*

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

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

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

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

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

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

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

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

ICD-10-CM/PCS:

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services;
  - Increased sensitivity when refining grouping and reimbursement methodologies;
  - Enhanced ability to conduct public health surveillance; and
  - Decreased need to include supporting documentation with claims.
- Includes updated medical terminology and classification of diseases.
- Provides codes to allow comparison of mortality and morbidity data.

- Provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
  - Processing claims;
  - Making clinical decisions;
  - Tracking public health;
  - Identifying fraud and abuse; and
  - Conducting research.

Structural Differences Between the Two Coding Systems

1. Diagnoses Codes

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

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

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

- A78 - Q fever;
- A69.21 - Meningitis due to Lyme disease; and
- S52.131a - Displaced fracture of neck of right radius, initial encounter for closed fracture.

2. Procedure Codes

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

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

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

- 0FB03ZX - Excision of Liver, Percutaneous Approach, Diagnostic; and
- 0DQ10ZZ - Repair upper esophagus, open approach

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

Additional Information

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

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

The ICD-10 Final Rule is available at **http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf** on the Internet.

Details on the ICD-10-CM Coding system, mappings, and guidelines may be found at **http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm** on the Internet and also at **http://www.cms.hhs.gov/ICD10/03_2008_ICD_10_CM.asp#TopOfPage** on the CMS Web site.

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

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

CMS News Flash (GEN)

Accreditation Deadline Fast Approaching - Time is running out for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B to obtain accreditation by the **September 30, 2009**, deadline or risk having their Medicare Part B billing privileges revoked on October 1, 2009. While the accreditation process takes on average 6-7 months to complete, the process could take as long as 9 months to complete. Accordingly, DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application. 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/03_DeemedAccreditationOrganizations.asp** on the CMS Web site.

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

An Introductory Overview of the HIPAA 5010 - A Special Edition *MLN Matters*® provider education article is now available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf** on the CMS Web site. This *Special Edition* article alerts providers regarding the implementation of HIPAA 5010 which presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to their electronic inquiries and outlines how providers need to plan for implementation of these changes.

Medicare Contractor Electronic Mailing Lists - Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare Administrative Contractor (MAC)) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor Web site and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for "listserv" or "e-mail list" to find the registration page. If you do not know the Web address of your contractor's homepage, it is available at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

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.

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

LCD and Policy Article Revisions - Summary for March 26, 2009 (GEN)

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

Ankle-Foot/Knee-Ankle-Foot Orthosis
LCD
Revision Effective Date: 06/01/2009
HCPCS CODES AND MODIFIERS:
Added: KX modifier
Deleted: L2770
DOCUMENTATION:
Added: Instructions for use of KX modifier with both the base and addition code(s)

Policy Article
Revision Effective Date: 06/01/2009
CODING GUIDELINES:
Deleted: Code L2035 from the custom-fabricated orthoses list
Deleted: Codes K0628 and K0629 from the list used in diabetic foot problems management
Added: Codes A5512 and A5513 to the list used in diabetic foot problems management
Added: Code L4392 to list of codes rejected as incorrect coding when billed with initial issue of a base orthosis

Wheelchair Options and Accessories
Policy Article
Revision Effective Date: 01/01/2009 (March Revision)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Corrected: Noncoverage statement for E2230
CODING GUIDELINES:
Deleted: Codes E0977, E0997-E0999, E2320, and K0099 from list of invalid codes. These codes have been discontinued

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

Beneficiary Request for Refill of Supplies, Accessories, and Drugs (GEN)

The *Medicare Claims Processing Manual*, Chapter 20, Section 200 states:

> *Suppliers/manufacturers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS. A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. A supplier may not initiate a refill of an order.* ***The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.***

Furthermore, the *Medicare Program Integrity Manual*, Chapter 4, Section 4.26.1 states:

> *For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. 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.*

Beneficiaries cannot "authorize" in advance the routine dispensing of DMEPOS items. Also, because of the time frames specified, the request for subsequent delivery cannot be made at the time of or soon after the current delivery of items. For example, when a beneficiary receives a supply of glucose test strips, it would not be acceptable for the beneficiary to tell the supplier at that time to deliver a new supply of test strips in 1-3 months.

Suppliers should document the request for a refill. This could be documented in a number of ways, including but not limited to, a postcard signed and dated by the beneficiary, written record of phone conversation between the supplier and beneficiary/caregiver, etc. The documentation must be available on request.

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.

CERT Documentation Checklist (GEN)

This documentation checklist emphasizes the most common DME items reviewed by CERT. The list is not all-inclusive. Please utilize the following references found within the CMS and DME MAC A Web sites for detailed and/or specific information:

- Local Coverage Determinations
- National Coverage Determinations
- *Supplier Manual*

Documentation	Oxygen & Supplies	CPAP & Supplies	Nebulizers, Medications & Supplies	Glucose Monitors & Diabetic Supplies
Detailed Written Physician Orders	X	X	X	X
Proof of Delivery	X	X	X	X
Physician Certification/Re-Certification (CMN)	X			
Specific Study Results	X	X		
Patient Instruction on use of device		X		X
Clinical Evaluation/Re-Evaluation and/or clinical records to support medical necessity	X	X	X	X
Over-Utilization documentation of Medical Necessity	X	X	X	X

FAQ - Complex Rehab Repair Issues (GEN)

Q1: Clarify the terms "repair" and "replacement" as used in the September 2003 bulletin on repair/replacement issues. Does the 5-year useful lifetime rule apply to replacement parts used to repair DME (e.g., tires and batteries)?

A1: Repair means to fix or mend. During the course of a repair, parts or components of a base item may be replaced. The replacement of parts or components that make up a base item is considered a repair. When the base item is completely replaced with a new base item, that is considered a "replacement". The default 5-year reasonable useful lifetime applies to replacement of the base item, not to parts and accessories.

Q2: How often can tires, batteries, etc. be replaced? If the claim denies for frequency limitations, does the supplier get a PR (patient responsibility) denial or a CO (contractual obligation) denial?

A2: No routine or prophylactic replacement is appropriate. Wear items such as batteries and tires are eligible for replacement as a repair to a wheelchair only when they become non-functional. Because the frequency of necessary replacement can vary so much depending on how an individual beneficiary uses his/her wheelchair, it is difficult to set a "usual" replacement frequency. Suppliers are reminded that they should maintain records documenting the need for the repair. Repairs are covered under Medicare only when made to medically necessary equipment. Thus, denials associated with repairs are considered "medical necessity" denials, which get a CO message - unless an ABN has been obtained.

Q3: For repairs to equipment not purchased by Medicare, what are the requirements?

A3: CMS policy is clear. IOM 100-2, Ch. 15, §110.2 states,

"*[P]ayment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the user enrolled in Part B of the program.*"

Key to implementing this provision is in understanding the criteria that the equipment is "medically required DME". The criteria means that all of the applicable benefit category and reasonable and necessary requirements for the base item must be met before the item is eligible to have repairs reimbursed. These criteria are generally found in the relevant LCD.

Q4: When repairs are made to equipment by a supplier who did not sell the equipment to the client, it is often difficult to get the correct date of purchase and HCPCS code. Although the repair supplier can verify through the IVR if Medicare paid a claim, that supplier does not know if the original supplier had the proper documentation and was paid properly. Is there a way the repair supplier can be protected?

A4: No. The requirement that repairs are covered for medically necessary equipment applies regardless of who is performing the repair.

Q5: When replacing a drive wheel for a power mobility device, because there is no HCPCS code for a complete power wheel, should this be billed using individual codes for the wheel, tire, and appropriate tube or insert, or should code K0108 be used for the entire assembly?

A5: In the situation described, it would be appropriate to use the codes for the individual components.

Q6: HCPCS code K0462 (temporary replacement for patient-owned equipment being repaired, any type) is used when a supplier provides a complete wheelchair to a beneficiary on a temporary basis if his/her wheelchair requires major repair (i.e., taking more than one day). Rehab power wheelchairs include sophisticated seating systems and advanced electronics that are highly individualized for the patient. Providing a similar loaner wheelchair is not possible. If a supplier is able to substitute a temporary replacement component while the patient's item is being repaired, can K0462 be used in that situation?

A6: Use of HCPCS code K0462 for temporary replacement is applicable when an appropriate complete item is provided or when swapping out individual components while leaving the beneficiary's base equipment in place as described in the scenario above. Suppliers are reminded that detailed records describing the nature of the repair and the justification for the temporary replacement of the item should be maintained.

Q7: With the new modifiers, RA & RB, is it correct to say that the RA modifier would only be used when replacing a full piece of equipment, e.g., a full wheelchair, that is over 5 years old or is being replaced due to a condition change?

A7: The RA modifier is used for replacement of the complete item due to reasonable useful lifetime or to accidental damage, theft, or loss. If a new item were provided due to a change in condition, it would be a different item, billed with a different HCPCS code, not a "replacement" of the original item. The RA modifier would not be used in this situation.

Q8: If a beneficiary refuses to bring their equipment to the supplier location, can they be charged a fee for this service?

A8: No, Medicare's payment for repairs, i.e., parts and labor, is all-inclusive. There is no separate payment for travel time, service charges, fuel surcharges, etc. On an assigned claim, suppliers may not charge a beneficiary for these costs. On a nonassigned claim, the beneficiary will be responsible for the difference between the submitted charges for the repairs and the amount Medicare pays.

Q9a: The reasonable useful lifetime for durable medical equipment is 5 years. If an item that is less than 5 years old needs to be repaired because of "wear and tear" (rather than a specific incident) and a thorough evaluation reveals that the cost to repair the equipment exceeds the cost to replace the equipment would Medicare consider payment for a replacement piece of equipment?

A9a: No, according to Medicare statute, during an item's reasonable useful lifetime, payment can only be made for repairs up to the cost of replacement.

Q9b: If the equipment has been repaired on several different occasions, is in need of repair again, and no single repair has exceeded the cost to replace the equipment but the cumulative repair costs will exceed the replacement cost, would Medicare consider payment for a replacement piece of equipment?

A9b: No, according to Medicare statute, during an item's reasonable useful lifetime, payment can only be made for repairs up to the cost of replacement.

Q9c: What percentage of repair to replacement cost would Medicare consider acceptable to deem the purchase of a replacement item more cost effective?

A9c: There is no provision for replacement due to "wear and tear" prior to the end of the item's useful lifetime.

Nebulizers - Documentation Guidance (SPE)

The Nebulizers local coverage determination (LCD) stipulates that for coverage of long-acting beta agonist (LABA) formulations the following criterion must be met:

It is medically necessary to administer formoterol (J7606) or arformoterol (J7605) for the management of chronic obstructive pulmonary disease (ICD-9 diagnosis codes 491.0-492.8, 496) and the patient has a documented history of routine use of at least four doses per day of an FDA-approved albuterol or metaproterenol inhalation solution or at least three doses per day of an FDA-approved levalbuterol inhalation solution.

Suppliers have inquired about how to document the "history of routine use" and the time required to be on a short acting beta agonist (SABA) before converting to formoterol or arformoterol. The supplier's records should reflect that the beneficiary has used SABA therapy at the frequencies listed in the coverage criteria for a period of three (3) months.

Suppliers should refer to the Nebulizer LCD for further information about coverage, coding and documentation requirements.

Ostomy Supplies - Billing Reminder (SPE)

A recent review of claims for ostomy supplies by the DME MAC Jurisdiction A, Medical Review, has identified billing discrepancies. This article is intended to serve as a reminder of the key policy elements.

Ostomy supplies are covered for use on patients with a surgically created opening (stoma) to divert urine or fecal contents outside the body. Ostomy supplies are appropriately used for colostomies 569.60, 569.62, V44.3, V55.3, ileostomies V44.2, V55.2 or urinary ostomies V44.6, V55.6. Use for other conditions will be denied as noncovered. The quantity of ostomy supplies needed by a patient is determined to a great extent by the type of ostomy, its location, its construction, and the condition of the skin surface surrounding the stoma.

Suppliers are reminded that the provisions of ostomy supplies should be limited to a one-month supply for patients residing in a nursing facility and a three-months supply for patients at home. Ostomy supplies are not separately payable when a patient is in a covered home health episode. Ostomy supplies must be provided by the home health agency and payment is included in the home health Medicare payment rate. It is not appropriate to bill these to the DME MAC.

For supplies billed in a home setting, the following processing guidelines will apply:

- If there is no indication of the number of months the supplier is billing for we will allow up to a 3-month supply.
- If there is indication on the claim of the number of months being billed, we will process as billed, up to a 3-month supply.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and be available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code. Suppliers must maintain the preliminary written order and this documentation must be available to the DME MACs upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is noncovered.

For detailed written orders, the following elements must be present:

- Beneficiary's name
- Description of the item
- Treating physician's name
- Start date of the order (if different from physician's signature date)

For ostomy supplies or any item that is dispensed on a periodic basis, the detailed written order must also include:

- Quantity to be dispensed
- Frequency of change
- Length or duration of treatment

In order to prevent denials, and submitting claims with overlapping dates of service, the claims must reflect the correct date the supplies are disbursed.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the *Ostomy Supplies LCD* L11502 and policy article. Suppliers can review the LCD and policy article on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

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

PAP Supplier FAQ Revised (SPE)

Question 16 of the *Positive Airway Pressure (PAP) Devices - Supplier Frequently Asked Questions* published December 2008 has been revised. After discussions with the Centers for Medicare & Medicaid Services (CMS), the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have revised previously published information related to the Advance Beneficiary Notice (ABN). The new response to question 16 shall read:

Q16: Would it be considered use of a blanket Advance Beneficiary Notice (ABN) to have all new PAP patients sign an ABN at the beginning of therapy stating that if they do not get a face-to-face evaluation or refuse to get the follow-up re-examination by their treating physician between the 31st and 91st day that Medicare will deny the claim?

A16: Yes, it would be considered a "blanket" ABN if the notice was presented at the beginning of therapy. The supplier may however, after day 60 following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not yet met the policy criteria for continued coverage. This ABN should advise the beneficiary that if, by the 90th day of therapy, they do not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face to face evaluation), Medicare may deny their subsequent claim(s) and that the beneficiary will be liable for payment.

This new guidance regarding a blanket ABN is effective for claims with initial dates of service on or after July 01, 2009. Advance beneficiary notices executed under the prior instructions contained in the December 2008 FAQ will still be considered valid until the July 01, 2009 effective date of this new instruction.

Positive Airway Pressure (PAP) Devices - Supplier Frequently Asked Questions - REVISED - July 2009 (SPE)

The answer to question 16 has been revised from the previous December 2008 publication of this FAQ.

Based on questions received from the clinical and supplier community, the following Frequently Asked Questions will address issues in the Positive Airway Pressure (PAP) Devices local coverage determination (LCD).

Ordering/Treating Physician Issues

Q1: The LCD uses the term "treating physician" in various places. What is the definition of a treating physician?

A1: Medicare statute defines treating physician as one "…who furnishes a consultation or treats the beneficiary for a specific medical problem and who uses the [diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests] results in the management of the beneficiary's specific medical problem." In a scenario where the beneficiary visits their primary care provider (PCP) who then refers the beneficiary to a sleep specialist for a polysomnogram and subsequent treatment with PAP and follow-up, both the PCP and the sleep specialist would be considered a "treating physician" within the context of Medicare regulations. Both physicians are engaged in diagnosing and treating the beneficiary for sleep disordered breathing. This scenario is quite common in medical practice where the primary medical care for the patient is rendered by the PCP and subspecialty physician consultation is engaged for specific diagnostic and/or therapeutic treatment outside the scope of the PCP's area of medical expertise.

Q2: Are nurse practitioners, clinical nurse specialists and physician assistants allowed to conduct the initial clinical evaluation and/or follow-up evaluation since the LCD states this must be done by the treating physician?

A2: Yes. Medicare regulations provide for the use of nurse practitioners, clinical nurse specialists and physician assistants in the care of Medicare beneficiaries. The Social Security Act §1861(s) addresses the provision of Medical and Other Services as follows:

Physician Assistants: (K)(i) services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Nurse Practitioners and Clinical Nurse Specialists: (K)(ii) services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Q3: Can a registered nurse (RN) conduct the follow-up evaluation?

A3: No, the treating physician must be directly involved in the follow-up evaluation.

Q4: The policy states that the data that the physician evaluates must be for a period of 30 consecutive days. The policy is silent on a time frame in which the physician must see the patient in relationship to the data.

A4: The physician may see the patient and conduct the follow-up evaluation between the 31st and 91st day. Continued coverage of a PAP device requires that a determination be made by the treating physician that the patient is benefiting from the use of the selected device as evidenced by a face-to-face clinical follow-up evaluation and adherence to therapy. While the documentation of adherence may occur following the treating physician's follow-up evaluation, the adherence report must be provided to the treating physician for inclusion in the patient's medical record in order to fulfill the requirement to assess therapy benefit. Consider the following example:

11/01/08	Patient set up with a PAP device
12/05/08	Face-to-face re-evaluation indicates subjective improvement, but objective data is not available
1/30/09	Supplier obtains data demonstrating adherent use; faxes to MD for review
2/01/09	Add KX modifier to fourth month's claim

Q5: Does the treating physician who does the initial face-to-face examination have to write the order for the PAP therapy or can it be ordered by the interpreting physician from the sleep lab?

A5: The treating physician that does the initial face to face exam does not have to be the same physician that orders the CPAP.

Q6: Is there a time limit from initial face-to-face evaluation to the sleep study?

A6: No time limit is specified in the policy; however, one would anticipate that these two events occur reasonably close together in time, typically within 3 months.

Adherence Monitoring

Q7: Help us understand the term "visual inspection" as it relates to adherence monitoring. What does this mean and how can it be documented?

A7: The LCD was revised to include allowance for visual inspection based on comments that not all suppliers use devices that allow downloading of adherence information. Visual inspection means determining adherence by looking at information on the PAP

device's display screen and documenting the values in a written report. As noted in a prior FAQ, the supplier may contact the beneficiary via telephone and ask them to read values from their device (i.e., phone-in compliance) or the supplier or physician may read the values during a home/office visit. The values must document that the patient is using the device for 4 or more hours per night for 70% of the nights in a consecutive 30-day period.

Q8: Can we report hours used, for example with information from a device with an hour meter, and meet the requirement for documenting adherence? For example, "Spoke to patient and she states that as of 12/01/08, there are a total of 650 hours on her CPAP machine. She states that she uses the CPAP every night and it is very beneficial. On 11/01/08, the beginning reading was 500 hours. This calculates to 5 hours per night for 30 days."

A8: No. Devices that simply report "device on" time or "blower on" time will not provide enough information to determine that the PAP device was used $\geq$ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

Q9: Several manufacturers have devices that report "sessions" of use. Are these types of devices acceptable to meet the LCD requirement for adherence?

A9: Possibly, depending on the definition of "session" which can vary based on the manufacturer or the session definition if a user-defined option. For example, consider a device that measures a "session" as use greater than X hours and also reports number of days used. Assuming that a session was set up to measure use $\geq$ 4 hours, one could use the number of session in conjunction with total days of use over a 30 day period and determine whether or not the patient met the adherence requirement.

Q10: We use devices from a manufacturer that reports adherence information on a rolling 30 day basis. Information is displayed in a window on the device; however, adherence may vary depending on which 30 day period is examined. How can we use this device and still meet the adherence requirement?

A10: Devices that report information on a rolling 30 day interval can be problematic if using visual inspection as the reporting method. One solution is to engage the beneficiary in their care and emphasize the importance of monitoring their therapy, including the potential loss of Medicare reimbursement for their PAP device due to failure to meet the adherence requirements. In the scenario with this specific piece of equipment, the supplier should instruct the beneficiary to monitor their device after the initial 30 days of use and report back to the supplier the point at which they meet the adherence metric.

Note that most devices that allow one to potentially determine adherence through visual inspection are designed to report adherence information in much greater detail via download. Suppliers are strongly encouraged to discuss the capabilities of devices being considered for purchase with each manufacturer to determine the capacity for reporting adherence as defined in the LCD.

Q11: Must suppliers continue to document adherence as defined in the LCD after the initial 3 month period?

A11: No. Following the initial 3 month trial and documentation of use $\geq$4 hrs. per night on 70% of nights in a 30 consecutive day period, suppliers should document continued use of the device. This may be accomplished via documentation of attestation by the beneficiary.

Reimbursement Issues

Q12: A patient received a CPAP device paid for by fee for service (FFS) Medicare in 1998 and now needs to replace their device. Do they have to get a face-to-face evaluation, a new sleep study and meet the other requirements in the new LCD?

A12: No. To receive a replacement CPAP device, they must have met the FFS Medicare coverage requirements that were in effect at the time their CPAP was dispensed, continue to use the device and have a new order from their treating physician. Continued

use of the device may be documented by the supplier upon attestation of the beneficiary. Additional information may be found in the *Repairs/Replacement Chart* published in 2003 by the Durable Medical Equipment Regional Carriers (DMERCs).

Q13: A patient was diagnosed with obstructive sleep apnea and received a PAP device paid for by private insurance. The patient is now enrolled in FFS Medicare and needs a replacement PAP device and/or accessories. What is required for coverage?

A13: For beneficiaries who received a PAP device prior to enrollment in FFS Medicare and are now seeking Medicare coverage of either a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test - There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories; and,
2. Clinical Evaluation - Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:
    a. The beneficiary has a diagnosis of obstructive sleep apnea; and,
    b. The beneficiary continues to use the PAP device.

If either criteria 1 or 2 above are not met, the claim will be denied as not medically necessary. The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of the beneficiary's enrollment in FFS Medicare.

Q14: DME company ABC conducts home sleep tests and then refers patients to DME company XYZ for PAP therapy after the physician makes the diagnosis of obstructive sleep apnea. Since the two companies are not related and DME company XYZ did not conduct the home sleep test, is DME company XYZ allowed to dispense the PAP device based on this test?

A14: No, a DME supplier is not a qualified provider of laboratory services; therefore, this is not a valid test for Medicare purposes. According to the PAP LCD, "No aspect of an HST [home sleep test], including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests."

Q15: If a patient is put on a RAD device with less than 30 day left in the initial 91 day period, the LCD indicates that the patient will be given to 120 days after the initiation of PAP therapy to document adherence. If the patient had a face to face exam in the 31 to 91 day period while on a CPAP device, must they have another face to face exam after they are on RAD? Certainly if they did not have a face to face exam in the 31 to 90 days we understand that one would need to be done before the 120th day.

A15: Yes, the patient would need to have a follow-up evaluation before the 120th day to determine benefit from the RAD device. This answer is based on the assumption that the reason the patient changed from a CPAP to RAD is the failure to show clinical benefit with the CPAP device. According to the NCD, continued coverage requires demonstration of therapy benefit within the first 90 days. The LCD recognizes that some patients may require a change in therapy to a RAD device and this transition may happen late in the first 90 day period such that an extension to 120 days is necessary.

Q16: Would it be considered use of a blanket Advance Beneficiary Notice (ABN) to have all new PAP patients sign an ABN at the beginning of therapy stating that if they do not get a face-to-face evaluation or refuse to get the follow-up re-examination by their treating physician between the 31st and 91st day that Medicare will deny the claim?

A16: Yes, it would be considered a "blanket" ABN if the notice was presented at the beginning of therapy. The supplier may however, after day 60 following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not yet met the policy criteria for continued coverage. This ABN should advise the beneficiary that if, by the 90th day of therapy, they do not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face to face evaluation), Medicare may deny their subsequent claim(s) and that the beneficiary will be liable for payment.

This new guidance regarding a blanket ABN is effective for claims with initial dates of service on or after July 01, 2009. Advance beneficiary notices executed under the prior instructions contained in the December 2008 FAQ will still be considered valid until the July 01, 2009 effective date of this new instruction.

Q17: What can a supplier do if the patient does not get in to see the treating physician within the 31st - 91st day?

A17: If the patient received the re-evaluation at a later date and it was documented that the patient was benefiting from the use of the PAP device, the supplier may begin submitting claims with the KX modifier from the date of that re-evaluation. Claims for services in the interim between the 91st day and the date of the re-evaluation must be submitted with the KX omitted.

Q18: What can be done in a situation where an order is received for PAP therapy but the patient never had a face-to-face evaluation? Can the face-to-face evaluation be done after the sleep test or after initiation of PAP therapy and will that meet our documentation requirements?

A18: The NCD and LCD require that prior to initiating PAP therapy, the patient has a clinical evaluation and sleep test. There is a sound clinical rationale for this specific sequence of events; therefore, a face-to-face evaluation performed after the sleep test or after the initiation of PAP therapy would not meet the coverage requirements and a KX modifier must not be added to the claim. Suppliers may obtain an ABN to inform the beneficiary that the PAP device will not be covered since the coverage requirements were not met.

Results of Advance Determination of Medicare Coverage (ADMC) Review (GEN)

A review, by DME MAC Jurisdiction A, of ADMC determinations received from March 01, 2008 through February 28, 2009 revealed a total of 2,718 ADMC requests were processed. Of the 2,718 requests, 628 (23%) were denied and 1286 (47%) were partially approved.

The primary reasons for ADMC denials are:

- 19% of the denials resulted from missing or incomplete documentation of one or more of the following:
  - No detailed product description
  - No home evaluation
  - Missing physician signature
  - Incomplete 7 element order
  - Incomplete description of HCPCS
  - No attestation of financial relationship
- 15% for no physician orders
- 16% for no inclusion of any of the required, listed below (Supporting Documentation)
- 13% for no face to face evaluation
- 37% Others

Note: *The "Others" involved denials of duplicate re-submission, beneficiary eligibility, incorrect supplier identification numbers and illegible ADMC documents.*

The following ***documentation requirements*** will help enhance a positive determination when submitting ADMC requests.

Supporting Documentation:
Manual Wheelchairs

- Detailed written order
- Information from patient's medical record supporting medical necessity
- Home assessment

Power Wheelchairs

- Detailed written order
- Detailed product description list
- Report of face-to-face examination
- Report of specialty evaluation
- Report of on-site home assessment
- Copy of supplier's attestation statement (if portion of face-to-face exam was performed by LCMP)

Suppliers must not use the miscellaneous Healthcare Common Procedure Coding System (HCPCS) code K0108 for a wheelchair accessory when a specific HCPCS code is available. In addition, a miscellaneous HCPCS code must not be billed for an accessory or component that is included in the payment for another HCPCS code. For information about the proper coding of accessories, suppliers should consult the LCD. Additional information about specific models/brand names and HCPCS codes may be found on the Pricing, Data Analysis and Coding (PDAC) contractor Web site in the Durable Medical Equipment Coding System (DMECS) tool at **http://www.dmepdac.com/dmecs**.

An ADMC request may be resubmitted if additional medical documentation is obtained that could affect the prior negative ADMC decision. However, requests may **only be submitted once** during a **six-month** period.

Please ensure all supporting medical necessity documentation is provided when submitting ADMC requests.

Suppliers can review LCDs, Policy Articles or Bulletins on the DME MAC A, Web site at: **http://www.medicarenhic.com/dme/medical_review/mr_index.shtml**.

You may also find useful information in Chapter 10 of the *DME MAC A Supplier Manual* located on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/suppmandownload.shtml**.

Supplies and Accessories Used With Beneficiary Owned Equipment - April 2009 Clarification (GEN)

The DME MACs recently published an article addressing documentation requirements for supplies and accessories used with beneficiary owned equipment. This article only addressed equipment that was not paid for by Medicare FFS - i.e., only equipment that was paid by other insurance or by the beneficiary. For supplies and accessories used with that equipment, all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

- HCPCS code of base equipment; and,
- A notation that this equipment is beneficiary-owned; and,
- Date the patient obtained the equipment.

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be denied for missing information.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the contractor or a redetermination request, suppliers should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on the relevant coverage, documentation and coding requirements.

Travel Oxygen (OXY)

A new payment policy for oxygen became effective on January 1, 2009. This article addresses issues related to short term travel (e.g., days or weeks) or to temporary relocation (e.g., snowbird) outside of the supplier's service area.

In this article, the term "oxygen" includes the equipment, contents (if applicable), and all related items and services including, but not limited to accessories, maintenance, and repairs.

In this article, the following terms are used:

- Home supplier refers to the supplier of the oxygen prior to travel or relocation.
- Temporary supplier (non-billing) refers to another supplier with whom the home supplier has made arrangements for provision of oxygen but who will not be billing Medicare for the oxygen. The home supplier will bill for the oxygen.
- Temporary supplier (billing) refers to a supplier in the travel/temporary location who will be billing Medicare for the oxygen instead of the home supplier.

36 Month Rental Period:

- In all cases, an oxygen supplier must provide or arrange for oxygen to be provided to the beneficiary for the entirety of each month for which it receives payment.
- Medicare will pay only one supplier to provide oxygen during any one rental month.
- Requirements for the home supplier:
  - If the beneficiary travels or relocates outside the supplier's service area, then for the remainder of the rental month for which it billed, the home supplier is required to provide the oxygen itself or arrange for a temporary supplier (non-billing) to provide the oxygen.
  - For subsequent rental months that the beneficiary is outside the service area, the home supplier is encouraged to either provide or arrange for the oxygen itself or assist the beneficiary in finding a temporary supplier (billing) in the new location.
  - If the home supplier provides oxygen to the patient for use out-of-area or arranges for a temporary supplier (non-billing) to provide the oxygen, the home supplier bills for whatever system the patient is using on the anniversary date/billing date. The supplier may provide the patient with different oxygen equipment (e.g., portable concentrator) for travel, if there is an order from the physician.
  - The home supplier may not bill for or be reimbursed by Medicare if it is not providing oxygen or has not arranged for a temporary supplier (non-billing) to provide the oxygen on the anniversary billing date.
- If a temporary supplier (billing) provides equipment:
  - If it is during a month in which the home supplier has not billed Medicare, claims from the temporary supplier (billing) would be paid, if all coverage criteria and payment rules are met.
  - If it is during a month in which the home supplier has billed Medicare and it is not provided under an arrangement with the home supplier, then the claim from the temporary supplier (billing) will be denied as not medically necessary, if it bills Medicare.
  - If the beneficiary returns home before the end of a rental month for which the temporary supplier (billing) has billed, it must provide oxygen itself for the entirety of that month or make arrangements with the home supplier to provide the oxygen.
  - The temporary supplier (billing) must provide a copy of a valid CMN, an order (if the order information was not included on the CMN), a report of the qualifying blood gas study, and documentation of any required physician visit, if requested.

Months 37-60:

- The supplier providing oxygen to the patient during the 36th month is required to provide oxygen to the patient either directly or under arrangements with a temporary supplier (non-billing) for beneficiary use out-of-area.

- The home supplier could provide the patient with different oxygen equipment (e.g., portable concentrator) for travel, if there is an order from the physician.
  - The supplier would not submit a claim for that equipment (because it is required to continue to provide equipment after the 36 month cap).

- If the beneficiary had a gaseous or liquid system during the 36th month and the supplier was providing contents to the patient during months 37-60, it may only bill and will only be reimbursed for contents if the patient was using contents at some time during the billed month. It may not bill for contents if, for example, the beneficiary was using a portable concentrator during the entire month.

Miscellaneous:

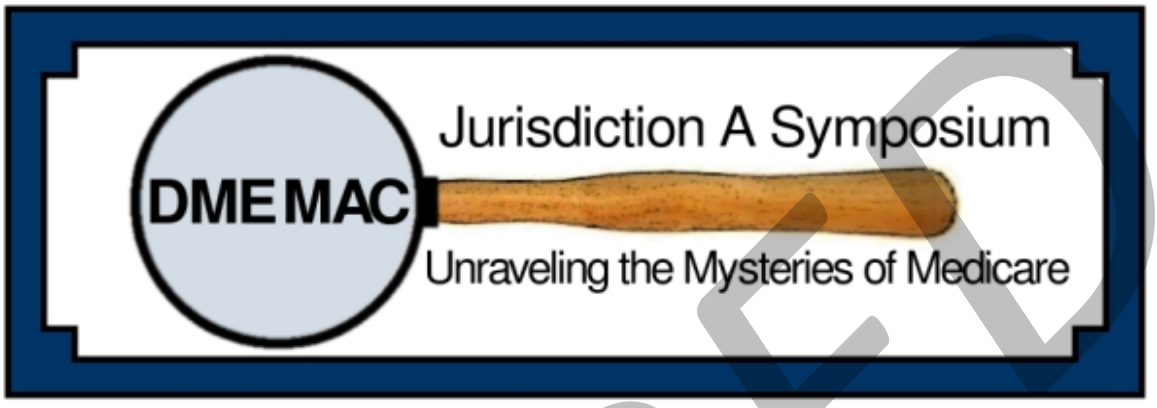
- Oxygen services furnished by an airline are noncovered. Payment for oxygen furnished by an airline is the responsibility of the beneficiary and not the responsibility of the supplier.

- This article only addresses travel and relocation in the United States and its territories. Medicare does not cover items or services provided outside the United States and the supplier is not required to provide or arrange for oxygen outside the United States.

DMEPOS Supplier Accreditation Deadline is September 30, 2009

(See page 19 for details)

Save the Dates!



The DME MAC Jurisdiction A Provider Outreach & Education Team is excited to announce that we will be hosting two Educational Symposiums offering a dynamic range of topics and speakers. In addition, attendees will have the opportunity to interact directly with various Medicare Contractors and State DMEPOS Associations in order to enhance their educational experience and get the most out of this excellent opportunity.

The Symposiums will be held on the following dates and locations:

Date	Location
August 19, 2009 (Wednesday)	**Four Points By Sheraton Norwood Hotel & Conference Center** 1125 Boston Providence Turnpike Norwood, MA 02062
September 02, 2009 (Wednesday)	**Crowne Plaza Hotel - Philadelphia/Cherry Hill** 2349 W. Marlton Pike Cherry Hill, NJ 08002

A Symposium Web page is available on the DME MAC A Web site, which can be accessed at:
http://www.medicarenhic.com/dme/symposium/Symposium_General_Information.shtml

This Web page will contain details and registration information as it becomes available. ListServe messages will be issued each time this page is updated with more information. NHIC, Corp. DME MAC Jurisdiction A would like to extend this invitation to all interested Jurisdiction A suppliers. Registration will be taken on a first come, first served basis until maximum capacity has been reached for each location. Please forward this information to all applicable individuals and keep watching for more details!

We look forward to seeing you there!

DME MAC Jurisdiction A Quarterly Ask-the-Contractor Teleconference (GEN)

The DME MAC A Outreach & Education Team will be holding our quarterly Ask-the-Contractor Teleconference (ACT) calls on Tuesday, June 16, 2009. The focus will be on **Glucose Monitor Billing Q&A**. The calls will last for approximately one hour and will begin promptly at the scheduled time. No registration is needed; however the number of lines will be limited.

ACT calls serve to identify issues in a timely way, provide methods of sharing information, and are an excellent tool to listen to our customers. This is your opportunity to interact directly with the DME MAC on the selected topic. We encourage all suppliers to participate!

For further details regarding ACT calls, go to: **http://www.medicarenhic.com/dme/dme_act.shtml#upcoming**

Be sure to read the participation instructions.

Test Your Knowledge Quiz Reminder (GEN)

In order to continue enhancing our educational efforts, DME MAC Jurisdiction A would like to remind suppliers of the ***Test Your Knowledge*** section of our Web site. The ***Test Your Knowledge*** section contains online quizzes that suppliers can take to gauge how well they answer some common Medicare questions. The results will also be used to detect educational needs among the supplier community and on an individual basis. New topics are added regularly.

After completing a quiz, users will be directed to the correct answers along with a short description of where they can find more information on each particular topic.

If you have been billing Medicare for years or are just starting out, stop by the DME MAC A Web site today and ***Test Your Knowledge!*** You may qualify for individual, one-on-one education by one of our Outreach Specialists. The Test Your Knowledge quizzes can be found on the DME MAC A Web site at **http://www.medicarenhic.com/dme/dme_quiz_index.shtml**

DME MAC A Self-Service Calculator Tools (GEN)

The Outreach & Education Team recently announced several new self-service calculator tools that have been developed to assist the supplier community in determining common calculations. With these self-service tools, you provide a few specific details and our calculators will do the math.

The following calculators are available:

- Claim Filing Calculator
- Capped Rental 13th Month Calculator
- Oxygen Rental 36th Month Calculator
- Enteral Nutrition Units of Service Calculator
- Five Year Useful Lifetime Calculator
- Redetermination Request Calculator
- Reconsideration Request Calculator

Additional self-service tools are under development for future implementation. The entire set of calculators can be found on the DME MAC A Self-Service Tools page at: **http://www.medicarenhic.com/dme/self-service.shtml**

First 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 January through March 2009, are provided in the following table.

Top Ten Claims Submission Errors	Number Received	Reason For Error
40022 - Procedure Code/Modifier Invalid	8,096	The procedure code and/or modifier used on this line is invalid.
40037 - Service Date Greater Than Receipt Date	1,617	The date of service is after the date the claim was received.
20322 - NPI Not Found on Crosswalk	1,394	The billing provider identifier is not found on the NPI crosswalk file.
20269 - Pointer 1 Diagnosis Invalid	1,184	Diagnosis pointer is invalid in first diagnosis field.
40068 - Invalid/Unnecessary CMN Question	1,177	The question number entered is not valid for the DME MAC CMN you are sending.
20011 - Billing Provider Invalid	851	The billing provider identifier in the 2010AA loop is invalid.
20025 - Subscriber ID Code Invalid	801	The Health Insurance Control Number (HICN) is invalid in the 2010BA loop.
20110 - Procedure Code Invalid	688	Procedure code is invalid or discontinued.
40014 - Ordering Provider Information Missing	652	The ordering provider information is missing in the 2420E loop.
40039 - From DT = TO Date and Units > 1	573	The procedure modifier is equal to RR and the number of services is greater than one (1).

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 first 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 January through March 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.	6,074
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.	2,963
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.	2,414
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).	2,409
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.	2,365
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.	1,933
CO 16 N257 Missing / incomplete / invalid billing provider / supplier primary identifier.	**Item 33** - PTAN number submitted in error. Must submit NPI.	1,264
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid ordering provider primary identifier.	**Item 17B** - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician.	1,260
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.	1,138
CO 16 M119 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid / deactivated / withdrawn National Drug Code (NDC).	**Item 24D** - Enter a valid National Drug Code (NDC).	1,070

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!

2009 Fees for Repair or Nonroutine Service for Durable Medical Equipment (DME) (JSM09213) (GEN)

Payment is allowed for reasonable and necessary repairs or nonroutine service of beneficiary-owned DMEPOS if not otherwise covered under an equipment warranty. Code K0739 was established to replace Code E1340 for Medicare claims for repair of beneficiary-owned DME (other than oxygen) with dates of service on or after April 01, 2009.

The below table identifies the 2009 fee schedule for E1340 and K0739. E1340 is effective for claims with dates of service from January 01, 2009, through March 31, 2009. K0739 is effective for claims with dates of service from April 01, 2009, through December 31, 2009.

State	E1340 / K0739
CT	22.40
DC	13.41
DE	24.71
MA	22.40
MD	13.41
ME	22.40
NH	14.40
NJ	18.10
NY	24.71
PA	14.40
RI	15.99
VT	14.40

Important Information Regarding NPI/PTAN NPPES Crosswalk (GEN)

For suppliers that have new or recently revised Provider Transaction Access Numbers (PTANs) from the NSC (National Supplier Clearinghouse) or if you are having difficulties establishing the crosswalk between your NPI (National Provider Identifier) and PTAN/NSC numbers, the following information must be verified with both the NSC and the NPPES Web site.

For Individuals:

- The Social Security number (SSN) and PTAN/NSC number entered with NPPES must match the SSN and PTAN/NSC number on file with the NSC.
- If a match cannot be found, the SSN and **Practice Address** ZIP Code at NPPES must match the SSN and **Practice Address** ZIP Code at the NSC.
- If the second match cannot be found, an active crosswalk record will not be created.

For Organizations:

- The Tax ID number (EIN), PTAN/NSC and **Practice Address** ZIP Code at NPPES must match the EIN, PTAN/NSC and Practice Address ZIP Code at the NSC.
- If the match cannot be found, an active crosswalk record will not be created.

Visit the NPPES Web site at **https://nppes.cms.hhs.gov/NPPES/Welcome.do** to verify or enroll the supplier's information. The PTAN/NSC number must be indicated under Issuer as MEDICARE NSC.

If you need assistance logging in to NPPES, call 1-800-465-3203.

If you have questions or do not have a PTAN/NSC number visit the National Supplier Clearinghouse Web site at: **http://www.palmettogba.com/nsc** or call 1-866-238-9652.

NSC News May 2009 (GEN)

The May 2009 National Supplier Clearinghouse (NSC) Supplier Newsletter has been published which includes important information on accreditation and surety bonds as well as a review of the appeals process and the requirements for completing the revised CMS-855S enrollment application for initial enrollment, reenrollments and changes of information. Suppliers are also provided with tips for successful site inspections.

To view the May 2009 NSC News, go to:
http://www.palmettogba.com/palmetto/Providers.nsf/vMasterDID/7SFLC76127?opendocument

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Updating Supplier Records (GEN)

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information **must** be reported in writing to the NSC **within 30 days** after such changes have taken place.

If you wait, your payments can be suspended. When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier **must** then verify their address with the NSC in writing.

Note: A request to change your address should not be sent to DME MAC A since we cannot change supplier files.

For instructions on the completion and mailing of CMS-855S, visit the CMS Forms Web site at **http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp** to download the Form.

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

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/**

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

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 March of 2009 **10 chapters** of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

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

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

For Your Notes

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

Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

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

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

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

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

Written Inquiries

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

Written Inquiry FAX: 781-741-3118

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

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

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

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

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

Redetermination Requests Fax: 781-741-3118

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

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

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

Local Coverage Determinations (LCDs)

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

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

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@examhub.exch.eds.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

NHIC, Corp.
Attention: ADMC
P.O. Box 9170
Hingham, MA 02043-9170

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: ngs.CEDIHelpdesk@wellpoint.com

DME MAC Jurisdiction A Resource

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

June 2009
Number 12

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 websites for more information:

- NHIC, Corp.: www.medicarenhic.com/dme/
- TriCenturion: www.tricenturion.com
- CMS: www.cms.hhs.gov/

The *DME MAC Jurisdiction A Resource*, together with occasional special releases, serves as legal notice to physicians and suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

If you have any comments about the *DME MAC Jurisdiction A Resource* or would like to make suggestions, please write to:

DME MAC Jurisdiction A Resource Coordinator
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Hingham, MA 02043

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An EDS Company
A CMS Contractor

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