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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General Information

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

Legend

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

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

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

MLN Matters Number: MM6062 - Revised
Related CR Release Date: December 5, 2008

Related CR Transmittal #: R1644CP

Related Change Request (CR) #: 6062
Effective Date: October 27, 2008, except December 12, 2008 for HCPCS code A4559
Implementation Date: October 27, 2008, except December 12, 2008 for HCPCS code A4559

Note: *This article was revised on December 8, 2008, to reflect that CR 6062 was revised by the Centers for Medicare & Medicaid Services on December 5, 2008. CR 6062 was revised to reflect a revised 2008 jurisdiction list to clarify that HCPCS code A4559 (coupling gel) may only be billed to the local carrier. The CR release date, transmittal number (above), and Web address for accessing CR 6062 were also revised. All other information remains the same.*

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

Impact on Providers
This article is informational and is based on Change Request (CR) 6062 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2008 Jurisdiction List is attached to CR6062 at **http://www.cms.hhs.gov/Transmittals/downloads/R1644CP.pdf** on the CMS Web site.

Additional Information
To see the official instruction (CR6062) issued to your Medicare DME MAC, carrier, or A/B MAC visit **http://www.cms.hhs.gov/Transmittals/downloads/R1644CP.pdf** on the CMS Web site.

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

April 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6380) (DRU)

MLN Matters Number: MM6380
Related CR Release Date: February 20, 2009
Related CR Transmittal #: R1685CP

Related Change Request (CR) #: 6380
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), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6380 which informs Medicare contractors that on or after December 16, 2008, the January 2009 Average Sales Price (ASP) file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. In addition, on or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the Centers for Medicare & Medicaid Services (CMS) ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary.

Background

The Medicare Modernization Act of 2003 (Section 303(c); see **http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf** on the CMS Web site) revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. The vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology. Pricing for compounded drugs is performed by your local Medicare contractor.

CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by the Social Security Act (Section 1847A; see **http://www.ssa.gov/OP_Home/ssact/title18/1847.htm** on the internet). As part of this effort, CMS has also reviewed how the terms "single source drug," "multiple source drug," and "biological product" have been operationalized in the context of payment under section 1847A.

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

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

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

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

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

ASP Methodology

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. Note that payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Integrated Outpatient Code Editor (I/OCE) through separate instructions.

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 these payment allowance limits quarterly.

Exceptions to this general rule as summarized below.

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood

and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the Ambulatory Payment Classification (APC) to which the product is assigned.

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

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

- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in the *Medicare Claims Processing Manual*, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2009, the blood clotting furnishing factor of $0.164 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

Note: *At the contractors' discretion, contractors may contact CMS to obtain payment limits for drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting contractor or via posting an MS Excel file on the CMS Web site.*

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005. Your Medicare contractor, at their discretion, may contact CMS to obtain payment limits for new drugs and biologicals not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, contractors will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

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

Quarterly Payment Files

On or after March 16, 2009, the April 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR 6380 (April 1, 2009) for the dates of service noted in the table that follows.

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

Payment Allowance Limit Revision Date	Applicable Dates of Service
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
April 2008 ASP and ASP NOC files	April 1, 2008, through June 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 will make these determinations.*

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); see **http://www.ssa.gov/OP_Home/ssact/title18/1842.htm** on the Internet) 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. 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.

Additional Information

The official instruction, CR 6380, 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/R1685CP.pdf** on the CMS Web site.

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

Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals (MM6295) (GEN)

MLN Matters Number: MM6295
Related CR Release Date: January 30, 2009
Related CR Transmittal #: R1676CP

Related Change Request (CR) #: 6295
Effective Date: May 4, 2009
Implementation Date: May 4, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6295, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2009.

The amount remaining in controversy requirement for **ALJ hearing requests** made before January 1, 2009, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2009, is $120.

For **Federal District Court** review, the amount remaining in controversy goes from $1,180 for requests **on or after January 1, 2008**, to $1,220 for requests **on or after January 1, 2009**.

Background
The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6295 modifies the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or judicial court review.

Additional Information
The official instruction (CR6295) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1676CP.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.

Changes in Payment for Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and Additional Instructions Regarding Payment for Durable Medical Equipment Prosthetics Orthotics & Supplies (DMEPOS) (MM6297) (OXY)

MLN Matters Number: MM6297
Related CR Release Date: December 23, 2008
Related CR Transmittal #: R421OTN
Related Change Request (CR) #: 6297
Effective Date: January 1, 2009
Implementation Date: January 6, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6297 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) **terminates all Round I supplier contracts awarded under the** DMEPOS Competitive Bidding Program, as a result of Section 154 of the MIPPA which delays the Program. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts. This article also provides guidance on the changes in payment for oxygen and oxygen equipment as a result of section 144(b) of the MIPPA of 2008, as well as, additional claims processing and payment instructions for DMEPOS items. **See the Key Points** of this article for specific instructions that impact you.

Background
Oxygen and oxygen equipment are paid on a fee schedule basis in accordance with section 1834(a)(5) of the Social Security Act. The Deficit Reduction Act of 2005 (DRA) limited monthly payments for oxygen and oxygen equipment to 36 months of continuous use, after which the equipment title transferred to the beneficiary. As part of the DRA rulemaking effort, CMS established beneficiary safeguards to ensure that suppliers would continue to maintain and service beneficiary-owned oxygen equipment after the 36-month cap. The safeguards included payment for periodic (every 6 months) general maintenance and servicing of beneficiary-owned oxygen equipment, payment for pickup of beneficiary-owned oxygen tanks that are no longer needed, and rules for furnishing or replacing oxygen equipment during the 36 month payment period.

MIPPA was enacted on July 15, 2008. Section 144(b) of the MIPPA repeals the transfer of ownership provision established by the DRA for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. This one-time update provides guidance on the changes in payment for oxygen and oxygen equipment resulting from Section 144(b) of the MIPPA. CR6297 also contains additional claims processing and payment instructions for DMEPOS. Specific instructions related to the

implementation of these changes will be issued in a separate CR (CR6296). Once CR 6296 is released, a related *MLN Matters* article will be available at
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6296.pdf on the CMS Web site.

Key Points in CR6297
Payment Policies for Oxygen and Oxygen Equipment and Capped Rental Following the Enactment of the MIPPA of 2008

- Section 154 of the MIPPA delays the Durable Medical Equipment ,Prosthetic, Orthotics & Supplies (DMEPOS) Competitive Bidding Program and terminates all Round I supplier contracts. Therefore, in the 10 areas where competitive bidding was initiated, Medicare will resume paying for DMEPOS items, retroactive to June 30, 2008, in accordance with the standard payment rules and fee schedule amounts.

- Medicare will pay no more than 13 continuous rental months for capped rental items and 36 continuous monthly payment amounts for oxygen and oxygen equipment.

- The competitive bidding policy that would have provided an additional 13 months of rental payments in situations where beneficiaries transitioned from non-contract suppliers to contract suppliers in the middle of the 13 month rental period for capped rental items is no longer valid. Therefore, for capped rental items, the supplier who received payment for the 13th continuous rental month must transfer title of the equipment to the beneficiary.

- The competitive bidding policy that would have provided a minimum of 10 monthly payments to contract suppliers in situations where beneficiaries transitioned from non-contract suppliers to contract suppliers in the middle of the 36 month rental period for oxygen and oxygen equipment is no longer valid. Therefore, for oxygen and oxygen equipment, the supplier who receives payment for the 36th continuous rental month must continue to furnish the oxygen and oxygen equipment until the reasonable useful lifetime of the oxygen equipment expires.

- Beneficiaries residing in the 10 competitive bidding areas for Round I may obtain oxygen and oxygen equipment and capped rental items and supplies from any Medicare-enrolled supplier and are not required to return to the supplier they were using before July 1, 2008.

New HCPCS Modifiers for Repair and Replacement

- The following two modifiers are being added to the HCPCS on January 1, 2009, and are effective for claims with dates of service on or after January 1, 2009:
  RA - Replacement of a DME item
  RB - Replacement of a part of DME furnished as part of a repair

- The existing RP modifier will be deleted from the HCPCS, effective 12/31/08.

- Suppliers should use the new RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. In contrast, the new RB modifier should be used on a DMEPOS claim to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).

- **Medicare contractors** will accept modifier "RA" rather than "RP" for replacement of beneficiary-owned DMEPOS due to loss, irreparable damage, or when the item has been stolen.

- **Medicare contractors** will accept modifier "RB" rather than "RP" for replacement parts furnished in order to repair beneficiary-owned DMEPOS.

Additional Instructions for Implementation of MIPPA 144(b) - Oxygen Equipment

- Section 144(b) of the MIPPA eliminates the requirement for suppliers to transfer title to oxygen equipment to the beneficiary following the 36th continuous month during which payment is made for the equipment. The requirement for suppliers to transfer title to the beneficiary for capped rental equipment following the 13th continuous month during which payment is made for the equipment remains in effect. As noted above, section 144(b) of MIPPA repealed the Deficit Reduction Act (DRA) transfer of title provision for oxygen equipment and allows suppliers to retain ownership of the oxygen equipment following the 36-month rental cap.

- The supplier who furnished the stationary and/or portable oxygen equipment during the 36-month rental period is required to continue furnishing the stationary and/or portable equipment following the 36-month rental period for any period of medical need for the remainder of the equipment's reasonable useful lifetime.

- The supplier who receives payment for furnishing the equipment during the 36th month of continuous use is responsible for furnishing the oxygen equipment at any time after the 36 month rental period and before the expiration of the reasonable useful lifetime of the oxygen equipment if the beneficiary has a medical need for oxygen and oxygen equipment furnished under Medicare Part B. This requirement includes situations where there is a temporary break in need or break in use of the equipment of any duration after the 36-month rental cap. In such situations, the supplier remains responsible for furnishing the oxygen equipment after the break in need for the remainder of the reasonable useful lifetime during which the medical need for oxygen and oxygen equipment continues.

- Following the 36-month cap, the supplier is responsible for furnishing all of the same necessary services associated with furnishing oxygen equipment that were furnished during the 36-month rental period. For example, as required by the Medicare quality standards for respiratory equipment, supplies, and services established in accordance with 1834(a)(20) of the Social Security Act, the supplier shall provide services 24 hours a day, 7 days a week as needed by the beneficiary. Suppliers may not bill beneficiaries separately for these services.

- Medicare oxygen equipment rental payments continue to be limited to 36 months and under no circumstances will a new rental period start following the completion of the 36-month rental period unless the equipment is replaced because it is lost, stolen, irreparably damaged, or is replaced after the reasonable useful lifetime expires.

- As indicated in section 30.6 of Chapter 20 of the *Medicare Claims Processing Manual* (Pub. 100-04), the monthly payment amount for oxygen and oxygen equipment covers equipment, contents, supplies and accessories. Section 144(b) of MIPPA caps the all inclusive oxygen and oxygen equipment monthly payments at 36 months and does not provide for payment of replacement oxygen supplies and accessories following the 36-month cap. The supplier who received payment for furnishing the oxygen and oxygen equipment during the 36-month rental period is responsible for continuing to furnish any accessories and supplies necessary for the effective use of the equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Therefore, separate payment shall not be made for replacement of supplies and accessories for use with oxygen equipment that are furnished on or after January 1, 2009. This applies to any supply or accessory billed under a miscellaneous HCPCS code, any codes added to the HCPCS in the future, or under the following current HCPCS codes:

HCPCS Code	Descriptor
A4608	Transtracheal oxygen catheter, each
A4615	Cannula, nasal
A4616	Tubing (oxygen), per foot
A4617	Mouth piece
A4619	Face tent
A4620	Variable concentration mask
A7525	Tracheostomy mask, each
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353	Regulator
E1354	Wheeled cart for portable cylinder or concentrator (Added to HCPCS effective January 1, 2009)
E1355	Stand/Rack

E1356	Battery pack/cartridge for portable concentrator (Added to HCPCS effective January 1, 2009)
E1357	Battery charger for portable concentrator (Added to HCPCS effective January 1, 2009)
E1358	DC Power adapter for portable concentrator (Added to HCPCS effective January 1, 2009)

- Instructions regarding claims for oxygen accessory or supply codes will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional Instructions for Implementation of MIPPA 144(b) - Oxygen Contents

- Section 144(b) of MIPPA also mandates that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment.

- Monthly payment for oxygen contents for beneficiary-owned liquid or gaseous oxygen equipment (stationary or portable) shall continue to be made in accordance with existing program instructions in section 30.6.3 of Chapter 20 of the *Medicare Claims Processing Manual* , which is available at **http://www.cms.hhs.gov/manuals/IOM/list.asp** on the CMS Web site. Suppliers should continue to use HCPCS codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents.

- Separate payment shall not be made under any circumstances for the pick up and disposal of liquid or gaseous oxygen equipment (i.e., tanks).

- Instructions regarding claims for oxygen contents will be provided in a separate transmittal/change request (CR 6296) that will be issued as part of the April 2009 release.

Additional Instructions for Implementation of MIPPA 144(b) - Maintenance and Servicing of Oxygen Equipment

- 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 under no circumstances would it be reasonable and necessary to pay for any maintenance and servicing or repair of supplier-owned oxygen equipment, with the exception of an in-home visit by suppliers to inspect oxygen concentrators and transfilling equipment and provide general maintenance and servicing 6 months after the 36-month rental cap.

- Additional claims processing and payment instructions regarding these maintenance and servicing visits will be furnished in a separate CR.

- 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 of 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. In no case shall payment be made for any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment.

- Payment shall not be made for loaner equipment furnished during periods when these repairs or maintenance and servicing services are performed.

Payment for Capped Rental Equipment Following the Enactment of MIPPA

- As noted above, MIPPA of 2008 did not eliminate or amend the provisions of the DRA of 2005 that apply to capped rental DME. All previously issued Medicare instructions relating to these provisions remain in effect, including the requirement for

suppliers to transfer title of the equipment on the first day after the 13th continuous month of use during which payment is made for the equipment.

MIPPA Remittance Advice (RA) Messages

- Although Section 144(b) of the MIPAA takes effect on January 1, 2009, the new Remittance Advice (RA) and Medicare Summary Notice (MSN) messages associated with this provision are not yet available. Therefore, in the interim, for claims with dates of service of January 1, 2009 and later, the following non-specific RA message will be used when paying the 36th month oxygen equipment claim:

  Reason Code 223: Adjustment code for mandated federal, state or local law/legislation that is not already covered by another code and is mandated before a new code can be created.

- Additional instructions related to the implementation of this provision of the MIPPA will be provided in the near future.

Revisions to the Labor Payment Rates Associated with Repairing DMEPOS Items

- As part of this update, CMS is revising the labor payment rates for HCPCS code(s) E1340, L4205, and L7520. The current rates were established based on historic supplier charges; however, annual inflation adjustments were not applied consistently from state to state. In addition, the rates differ dramatically among the states in the continental United States (e.g., from $9.51 to $23.53 in the case of E1340). To reduce this span and correct the disparity in payments for codes E1340, L4205, and L7520, CMS is revising the fees to apply inflation updates in years where it determined that these updates were not provided. Secondly, state payment amounts below the median state payment amount are being increased to the median state payment amount for each code. These changes are effective for claims with dates of service on or after January 1, 2009.

- Attachment A (see *Additional Information* section of this article) contains the revised 2009 payment amounts for HCPCS codes E1340, L4205, and L7520. The payment rates include all costs (other than replacement of parts) associated with repairing DMEPOS items.

- Suppliers should only bill in 15 minutes for the time spent repairing the item and cannot bill for the time spent traveling to the beneficiary's home.

- The rates established for codes E1340, L4205, and L7520 are based on 25 percent (¼) of the previous hourly repair rates for codes E1350, L4200, and L7500, respectively. The supplier's travel costs are assumed to have been taken into account by suppliers in setting the prices they charged for these services under these codes. As such, these costs have already been accounted for in the calculation of the rates for codes E1340, L4205, and L7520. Therefore, separate payment shall not be made for travel costs associated with repairing DMEPOS items. In addition, suppliers may not bill beneficiaries directly for travel charges.

- **DME MACs, RHHIs and Medicare Carriers and/or MACs** will use the 2009 allowed payment amounts for code E1340 in *Attachment A* (see *Additional Information* section of this article) to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned DME with dates of service from January 1, 2009, through December 31, 2009.

- DME MACs, FIs, Medicare Carriers and/or MACs will use the 2009 allowed payment amounts for codes L4205 and L7520 in *Attachment A* to pay claims for the labor associated with reasonable and necessary repairs of beneficiary-owned orthotics, prosthetics, and prosthetic devices with dates of service from January 1, 2009, through December 31, 2009.

Medicare Coverage of Elastic Support Garments

- CMS has received questions regarding coverage of elastic support garments such as leg, arm, back, or neck braces (orthotics). The definition of a brace in section 130 of Chapter 15 of the *Medicare Benefit Policy Manual* specifies that:

  A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace.

  Elastic garments or devices in general do not meet the definition of a brace because they are not rigid or semi-rigid devices. This includes devices that include stays that do not provide sufficient pressure to restrict or eliminate motion in the body part. While elastic devices may provide compression or warmth to a leg, arm, back, or neck, if they do not restrict or eliminate motion in a diseased or injured part of the body, then they may not be covered as braces. When a Medicare contractor identifies an elastic device that does not meet the Medicare definition of a brace, they shall not cover claims submitted for

these devices and they shall not classify such devices under a HCPCS code that describes items that do meet the Medicare definition of a brace.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction, CR6297, issued to your Medicare FI, RHHI, DME/MAC, or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R421OTN.pdf** on the CMS Web site.

For more information on CR5461, you may go to **http://www.cms.hhs.gov/Transmittals/downloads/R1177CP.pdf** on the CMS Web site. The related *MLN Matters* article may be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5461.pdf** on the CMS Web site.

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

Attachment A
2009 Repair and Service Fees, 15 minute unit

STATE	E1340	L4205	L7520		STATE	E1340	L4205	L7520
AK	23.59	28.79	33.88		NC	13.41	19.99	27.14
AL	24.71	19.99	27.14		ND	13.41	28.73	33.88
AR	24.71	19.99	27.14		NE	13.41	19.97	37.84
AZ	22.40	19.97	33.39		NH	13.41	19.97	27.14
CA	22.40	32.83	38.26		NJ	15.99	19.97	27.14
CO	22.40	19.99	27.14		NM	14.00	19.99	27.14
CT	19.95	20.45	27.14		NV	14.40	19.97	36.99
DC	19.95	19.97	27.14		NY	14.40	19.99	27.14
DE	19.22	19.97	27.14		OH	14.40	19.97	27.14
FL	17.46	19.99	27.14		OK	13.41	19.99	27.14
GA	18.10	19.99	27.14		OR	13.41	19.97	39.03
HI	15.61	28.79	33.88		PA	13.41	20.56	27.14
IA	15.49	19.97	32.49		PR	13.41	19.99	27.14
ID	15.49	19.97	27.14		RI	13.41	20.58	27.14
IL	13.41	19.97	27.14		SC	13.41	19.99	27.14
IN	13.41	19.97	27.14		SD	13.41	19.97	36.28
KS	13.41	19.97	33.88		TN	13.41	19.99	27.14
KY	13.41	25.60	34.71		TX	13.41	19.99	27.14
LA	13.41	19.99	27.14		UT	13.41	19.97	42.27
MA	15.32	19.97	27.14		VA	13.41	19.97	27.14
MD	13.41	19.97	27.14		VI	13.41	19.99	27.14
ME	13.41	19.97	27.14		VT	13.41	19.97	27.14
MI	13.41	19.97	27.14		WA	13.41	29.30	34.80
MN	13.41	19.97	27.14		WI	13.41	19.97	27.14
MO	13.41	19.97	27.14		WV	13.41	19.97	27.14
MS	13.41	19.99	27.14		WY	13.41	26.65	37.84
MT	13.41	19.97	33.88					

Claim Status Category Code and Claim Status Code Update (MM6328) (GEN)

MLN Matters Number: MM6328
Related CR Release Date: December 31, 2008
Related CR Transmittal #: R1656CP

Related Change Request (CR) #: 6328
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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

Provider Action Needed
Change Request (CR) 6328, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background
The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response transactions.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6328 updates the changes in the Claim Status Codes and Claim Status Category Codes from the June, 2008 committee meeting. These updates were posted at **http://www.wpc-edi.com/content/view/180/223/** on June 30, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by January 5, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

Additional Information
If you have questions, please contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the Centers for Medicare & Medicaid Services (CMS) Web site. The official instruction (CR6328) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1656CP.pdf** on the CMS Web site.

Claim Status Category Code and Claim Status Code Update (MM6325) (GEN)

MLN Matters Number: MM6325
Related CR Release Date: January 16, 2009
Related CR Transmittal #: R1670CP

Related Change Request (CR) #: 6325
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

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

Provider Action Needed
Change Request (CR) 6325, from which this article is taken, reminds providers of the periodic updates to the Claim Status Codes and Claim Status Category Codes that Medicare contractors use with the Health Care Claim Status Request (ASC X12N 276), and the Health Care Claim Response (ASC X12N 277).

Background
The Claim Category and Claim Status Codes explain the status of submitted claims. The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only national Code Maintenance Committee-approved codes in the X12 276/277 Health Care Claim Status Request and Response transactions.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) to decide about additions, modifications, and retirement of existing codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

CR 6325 updates the changes in the Claim Status Codes and Claim Status Category Codes from the September, 2008 committee meeting. These updates were posted at **http://www.wpc-edi.com/content/view/180/223/** on November 1, 2008. Medicare contractors must have completed the entry of all applicable code text changes and new codes, and terminated the use of deactivated codes by April 6, 2009. On and after this date, these code changes are to be used in editing of all X12 276 transactions processed and must be reflected in the X12 277 transactions issued.

Additional Information
If you have questions, please contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the Centers for Medicare & Medicaid Services (CMS) Web site. The official instruction (CR6325) issued to your Medicare MAC, carrier, DME MAC, FI, and/or RHHI is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1670CP.pdf** on the CMS Web site.

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

MLN Matters Number: SE0822 - 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 January 7, 2009, to delete the first question and answer that was previously on page 2. All other information remains the same.*

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

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

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

"40 No Legal Obligation to Pay for or Provide Services

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

Key Points of SE0822

There are two concerns addressed in this article regarding "Payment for Routine Costs in a Clinical Trial" and they are addressed in the following questions and answers:

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

   Answer: If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts. As noted at **http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/FAQ_Uninsured.pdf**, "nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations or Program Instructions prohibit a hospital from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the hospital's indigency policy. By "indigency policy" we mean a policy developed and utilized by a hospital to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal health care program - a highly unlikely circumstance.

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

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

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

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

Additional Information

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

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

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

CMS wants to remind suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare under Part B that they must obtain accreditation by **September 30, 2009**. 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 Medicare's supplier and quality standards and become accredited. DMEPOS suppliers should contact an accreditation organization right away to obtain information about the accreditation process and submit an application.

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

DMEPOS suppliers submitting applications to an accrediting organization, on or after February 1, 2009, ***may or may not*** *have their accreditation decision by the September 30, 2009 deadline.*

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, 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:
http://www.cms.hhs.gov/medicareprovidersupenroll

Fee Schedule Updates (GEN)

The 2009 fee schedules and subsequent updates are available via the "Fee Schedules" section of the DME MAC A Web site at: **http://www.medicarenhic.com/dme/dmfees.shtml**. The following notices have been posted:

- 2009 Jurisdiction A DME MAC Fee Schedule
- January 2009 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.

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: February 25, 2009
Related CR Transmittal #: R24COM

Related Change Request (CR) #: 6139
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Note: *This article was revised on February 26, 2009, to reflect the revised CR 6139, which CMS re-issued on February 25, 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/R24COM.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.

Incorporation of Recent Regulatory Revisions Pertinent to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (MM6282) (GEN)

MLN Matters Number: MM6282
Related CR Release Date: December 31, 2008
Related CR Transmittal #: R280PI

Related Change Request (CR) #: 6282
Effective Date: February 2, 2009
Implementation Date: February 2, 2009

Provider Types Affected

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

Provider Action Needed
This article is informational in nature and based on Change Request (CR) 6282 which incorporates recent regulatory changes and applicable instructions for the National Supplier Clearinghouse - Medicare Administrative Contractor (NSC-MAC) into the *Medicare Program Integrity Manual* (Chapter 10 (Healthcare Provider/Supplier Enrollment)).

Background
The *Medicare Program Integrity Manual* (Chapter 10) specifies the procedures Medicare fee-for-service contractors must use to establish and maintain provider and supplier enrollment in the Medicare program. Change Request (CR) 6282 incorporates National Supplier Clearinghouse - Medicare Administrative Contractor (NSC-MAC) instructions into the *Medicare Program Integrity Manual*, Chapter 10 (Healthcare Provider/Supplier Enrollment), Section 21 (Special Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Instructions).

These NSC-MAC instructions evolved from recent regulatory revisions regarding the following topics:

- The timeframe in which providers and suppliers must furnish developmental information to the NSC-MAC;
- Effective dates of certain types of revocations;
- Alert codes; and
- Accreditation.

A complete description of these NSC-MAC instructions/topics is included as an attachment to CR 6282, and the following provides a summary:

1) The timeframe in which providers and suppliers must furnish developmental information to the contractor
A Medicare contractor (including the NSC-MAC) may reject a provider/supplier's application if the provider/supplier fails to furnish complete information on the enrollment application, including all supporting documentation, within 30 calendar days from the date of the contractor's request for the missing information or documentation.

The 30-day clock starts on the date the pre-screening letter was sent to the provider/supplier. If the contractor makes a follow-up request for information, the 30-day clock does not start anew; rather, it keeps running from the date the pre-screening letter was sent. To illustrate, suppose that the contractor sent out a pre-screening letter on March 1 (thus triggering the 30-day clock) that asked for clarifying information in Sections 4 and 5 of the CMS-855B. (All supporting documentation was provided.) The provider sent in most, but not all of the requested data. Though not required to make an additional contact beyond the pre-screening letter, the contractor telephoned the provider on March 20 to request the remaining missing data. The provider failed to respond. The contractor can reject the application on March 31, which is 30 days after the initial request.

2) Effective dates of certain types of revocations
A revocation is effective 30 days after the Centers for Medicare & Medicaid Services (CMS) or the Medicare contractor (including the NSC-MAC) mails the notice of its determination to the provider or supplier. However, a revocation based on a Federal exclusion or debarment is effective with the date of the exclusion or debarment. In addition, if the revocation was due to the revocation or suspension of the provider/supplier's license or certification to perform Medicare services, said revocation can be made retroactive to the date of the license suspension/revocation.

3) Alert codes
The NSC-MAC will receive and maintain "alert indicators" based on findings from the DME-MACs as well as on information received from Medicare's Program Integrity contractors.

4) Accreditation
The NSC-MAC will follow the accreditation requirements in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Individual medical practitioners, inclusive of group practices of same, will not currently require accreditation for enrollment. The practitioner types are those specifically stated in Sections 1848(K)(3)(B) and 1842(b)(18)(C) of the Social Security Act as Amended. In addition, the practitioner categories of physicians, orthotists, prosthetists, optometrists, opticians, audiologists, occupational therapists, physical therapists and suppliers who provide drugs and pharmaceuticals (only) will not currently require accreditation for enrollment.

Suppliers that fall in this subset who provide other durable medical equipment outside of their specialty are required to be accredited to bill Medicare as a DMEPOS supplier. DMEPOS companies that are owned by any exempted individuals are NOT exempt from accreditation. For example, physicians are exempt from accreditation requirements for supplies they provide to their physician practice

patients; however, if a physician owns a DMEPOS company, that company is NOT exempt from accreditation. Similarly, suppliers that provide only drugs and pharmaceuticals are exempt from the accreditation requirement; however, if the supplier provides equipment to administer drugs or pharmaceuticals, the supplier must be accredited.

If a previously exempted supplier enrollment application was returned for non-accreditation, the supplier must resubmit its CMS 855S Medicare enrollment application to the NSC to obtain/maintain Medicare billing privileges.

Additional Information
The official instruction, CR 6282, issued to your DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R280PI.pdf** on the CMS Web site.

If you have any questions, please contact 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.

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 February 17, 2009, to include a Web link to CR6280, 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; and

CR 6280, which is available at **http://www.cms.hhs.gov/Transmittals/downloads/R441OTN.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.

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

MLN Matters Number: MM6211
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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 6211 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 6211 is limited to providers billing Part B contractors (carriers and MACs) and DME/MACs.

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

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 claim adjustment (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 6211 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements, 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 segments 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 *Medicare Secondary Payer Manual*, which is available at http://www.cms.hhs.gov/manuals/IOM/list.asp on the CMS Web site and in the federal regulations at 42 CFR 411.32 and 411.33.**

Additional Information
The official instruction, CR 6211, issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R62MSP.pdf** on the CMS Web site.

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

January 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6288) (DRU)

MLN Matters Number: MM6288
Related CR Release Date: December 19, 2008
Related CR Transmittal #: R1650CP
Related Change Request (CR) #: 6288
Effective Date: January 1, 2009
Implementation Date: January 5, 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
CR 6288, from which this article is taken, instructs Medicare contractors to download and implement the January 2009 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2008, July 2008, April 2008, and January 2008 files. They will use the January 2009 ASP and NOC drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 5, 2009 with dates of service January 1, 2009, through March 31, 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 average sales price (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), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.

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

ASP Methodology

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

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

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid 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.. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

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

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

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

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

payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2008, the blood clotting furnishing factor of $0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2009, the blood clotting furnishing factor of $0.164 per I.U. is added.**

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

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

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

Quarterly Payment Files

On or after December 16, 2008, the January 2009 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after December 16, 2008, the January 2009 ASP NOC files will be available for retrieval from the CMS ASP Web page along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment files will be applied to claims processed or reprocessed on or after the effective date of CR6288 for the dates of service noted in the following table:

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

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

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

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

Payment Allowance Limit Revision Date	Applicable Dates of Service
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
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008

Additional Information

You can find the official instruction, CR6288, issued to your carrier, FI, RHHI, MAC, or DME MAC by visiting

http://www.cms.hhs.gov/Transmittals/downloads/R1650CP.pdf on the CMS Web site.

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

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
Related CR Release Date: January 9, 2009
Related CR Transmittal #: R1665CP

Related Change Request (CR) #: 5371
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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 at **http://www.cms.hhs.gov/Transmittals/downloads/R1665CP.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.

Payment for Repair, Maintenance and Servicing of Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (MM6296) (OXY)

MLN Matters Number: MM6296
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R443OTN

Related Change Request (CR) #: 6296
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Provider Types Affected
Providers and suppliers submitting claims to Medicare DME Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for repair, maintenance and servicing of oxygen equipment provided to Medicare beneficiaries

Provider Action Needed
This article is based on Change Request (CR) 6296 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is providing instructions regarding repair, maintenance, and servicing of oxygen equipment resulting from implementation of Section 144(b) of the MIPPA. The 36-month cap noted in MIPPA 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 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 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 E1340 (K0739 for dates of service on or after April 1, 2009) multiplied by 2, for the state in which the in-home visit takes place.

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

CMS will issue further instructions in the future regarding continuation of these payments for dates of service on or after January 1, 2010.

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. Initial instructions related to implementation of these changes were issued as part of the January 2009 Durable Medical Equipment Prosthetics Orthotics & Supplies (DMEPOS) Fee Schedule Update, CR 6297. The *MLN Matters* article related to CR6297 may be viewed at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf** on the CMS Web site.

Key Points in CR6296

- To distinguish between the repair or nonroutine service of beneficiary-owned DME and oxygen equipment, two new "K" codes are effective for claims with dates of service on or after April 1, 2009. Those "K" codes are:
  - K0739 - Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes
  - K0740 - Repair or Nonroutine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes

- The new non-covered code K0740 should be used by suppliers to indicate the labor associated with the repair of stationary or portable oxygen equipment.

- The existing E1340 HCPCS code is invalid for Medicare claims, effective April 1, 2009. The revised 2009 labor payment rates, provided in CR 6297, map directly to the new K0739 code and will be used to pay claims for code K0739 with dates of service on or after April 1, 2009.

- **Note that the two new codes are not yet final and should not be used until effective on April 1, 2009.**

- DME MACs and RHHIs:
  - Deny claims with dates of service on or after April 1, 2009 for HCPCS code K0740.

  - Will deny claims with dates of service on or after January 1, 2009, for claims received on or after April 6, 2009, for replacement parts billed using a HCPCS code and the "RB" modifier when the part is replaced in conjunction with the repair of oxygen equipment identified by HCPCS codes E0424, E0431, E0434, E0439, E1390, E1391, E1392, E1405, E1406, or K0738.

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (CR 6296) issued to your Medicare DME MAC, or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R443OTN.pdf** on the CMS Web site.

If you have questions, please contact your DME MAC and 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.

Providers Urged to Participate in Annual Medicare Contractor Satisfaction Survey (MCPSS) (SE0843) (GEN)

MLN Matters Number: SE0843
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
Medicare physicians, providers, and suppliers selected to participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS).

Provider Action Needed
This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) will **distribute its annual MCPSS to a new sample of Medicare providers**. CMS is sending the 2009 survey, designed to be **completed in about 20 minutes**, to approximately 30,000 randomly selected providers, including physicians and other health care practitioners, suppliers and institutional facilities that serve Medicare beneficiaries across the country. CMS will begin to notify providers selected to participate in the survey in December 2008. **Providers are urged to submit their responses via a secure Web site, mail, fax, or over the telephone.**

Background
The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. All Medicare Administrative Contractors (MACs) will be measured against performance targets on the 2009 MCPSS as part of their contract requirements.

The 2008 survey results revealed that, for the second consecutive year, the top indicator of satisfaction among providers was how Medicare contractors handled provider inquiries. As in the two previous years, claims processing also remained a strong indicator in 2008 of provider satisfaction across all contractor types. The shift from claims processing as the top predictor in 2006 to provider

inquiries as the top predictor of satisfaction in 2008 is an example of the type of trend data the MCPSS will reveal. Contractors are able to factor such insights into how they prioritize their provider-focused efforts.

Feedback captured through MCPSS is important, and CMS urges all Medicare providers who are selected to participate in the MCPSS to complete and return their surveys upon receipt. CMS plans to analyze the 2009 MCPSS data and release a summary report at **http://www.cms.hhs.gov/MCPSS** on the CMS Web site in July 2009.

Key Points

- Survey questions focus on seven business functions of the provider-contractor relationship: provider inquiries, provider outreach and education, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement.

- Respondents are asked to rate their contractors using the 1 to 6 scale on each of the business functions with "1" representing "not at all satisfied" and "6" representing "completely satisfied." Contractors receive an overall composite score as well as a score on each business function.

- Results from previous surveys have enabled CMS to set performance standards for MAC's.

- Performance standards give contractors a benchmark to use to compare themselves to other contractors, as well as an individual standard to improve upon year after year.

- The contractor's MCPSS score is based on the average survey score from all surveyed Medicare providers in the contractor's jurisdiction. To meet the performance standard, the MAC's score for the 2009 MCPSS must fall within a specified range of the 2008 national mean score. The average 2008 MCPSS for all contractors, released last August, was 4.51 on a scale of 1 to 6. This score was comparable to the 2007 average MCPSS score of 4.56. CMS plans to utilize MCPSS results to help structure future contract incentives.

  The MCPSS is required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Specifically, the law calls for CMS to develop contract performance requirements, including measuring health care provider satisfaction with Medicare contractors. The MCPSS enables CMS to make valid comparisons of provider satisfaction between contractors and, over time, improvements to the Medicare fee-for- service program.

Additional Information

For further information, visit **http://www.cms.hhs.gov/MCPSS** 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.

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Updates (CR6336) (GEN)

Effective April 01, 2009 Change Request (CR) 6336 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 CR6336 at: **http://www.cms.hhs.gov/transmittals/downloads/R1674CP.pdf**

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

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update (MM6336) (GEN)

MLN Matters Number: MM6336
Related CR Release Date: January 30, 2009
Related CR Transmittal #: R1674CP

Related Change Request (CR) #: 6336
Effective Date: April 1, 2009
Implementation Date: April 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 provided to Medicare beneficiaries.

Provider Action Needed
CR 6336, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2009 for Medicare. Be sure billing staff are aware of these changes.

Background
Two code sets - the Group and the reason ~~and remark~~ code sets - must be used to report payment adjustments in remittance advice transactions. For Medicare, remark codes must also be used when appropriate to report additional explanation for any adjustment or to provide general policy information. 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. RARC list is updated 3 times a year - in early March, July, and November although the Committee meets every month.

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

Both code lists are updated at the same time and 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 6336.

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
To see the official instruction (CR6336) issued to your Medicare Contractor refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1674CP.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 use the Medicare Remit Easy Print software from your Medicare Contractor, you may need to download the updated version when it is available on April 6, 2009.

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.

New Codes - CARC:

Code	Current Narrative	Effective Date
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.)	9/21/2008

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.)	9/21/2008
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008

Modified Codes - CARC:

Code	Current Modified Narrative	Effective Date
148	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.)	7/1/2009

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
B18	This procedure code and modifier were invalid on the date of service.	3/1/2009

New Codes - RARC:

Code	Current Narrative	Medicare Initiated?
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.	NO
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.	NO
N507	Plan distance requirements have not been met.	NO
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.	NO
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.	NO
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	NO
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.	NO
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	YES
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	YES

Modified or Deactivated Codes - RARC

There are no modified or deactivated RARC codes in CR 6336.

Signature and Date Stamps for DME Supplies-Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs) (MM6261) (GEN)

MLN Matters Number: MM6261
Related CR Release Date: December 31, 2008
Related CR Transmittal #: R281PI

Related Change Request (CR) #: 6261
Effective Date: February 2, 2009
Implementation Date: February 2, 2009

Provider Types Affected
Providers and suppliers submitting claims, CMNs, or DIFs to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) related to durable medical equipment, prosthetic, and orthotic supplies (DMPEOS) provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6261 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions regarding signature requirements for CMNs and DIFs. Signature and date stamps are not acceptable for use on CMNs and DIFs. Be sure your billing staffs are aware of this change. Your Medicare contractors will accept only hand written, facsimiles of original written and electronic signatures and dates on medical record documentation for medical review purposes on CMNs and DIFs.

Background
CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for durable medical equipment, prosthetic, and orthotic supplies (DMPEOS) have been meet. The *Program Integrity Manual* (PIM), Chapter 3, section 3.4.1.1, which may be reviewed at **http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf** on the CMS Web site, states that Medicare requires a legible identifier for services provided/ordered. The **method used should be hand written including facsimiles of original written or an electronic signature in accordance with Chapter 3, Section 3.4.1.1** to sign an order or other medical record documentation for medical review purposes. Signature and date stamps are not acceptable for use on CMNs and DIFs.

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

For complete details regarding this Change Request (CR) please see the official instruction (CR6261) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R281PI.pdf** on the CMS Web site.

Updated Healthcare Provider Taxonomy Code (HPTC) List Codes Effective April 1, 2009 (CR6382) (GEN)

A list of **Healthcare Provider Taxonomy Codes (HPTCs)**, effective April 1, 2009, is available on the Washington Publishing Company (WPC) web site at: **http://www.wpc-edi.com/codes/taxonomy**

Use of the taxonomy code is not required on Medicare DME MAC Jurisdiction A claims. However, **if used, the code must be the correct code**. To avoid delays in the processing of your claims, please ensure you are using only the latest HPTC code list. New code values may not be used prior to the effective date and prior code may not be used after the new code effective date. Although updates may be posted on the WPC Web site up to 3 months prior to the effective date, changes are not effective until the date noted.

If you have any questions regarding the new HPTC list please contact CEDI at **866-311-9184** or **ngs.CEDIHelpdesk@wellpoint.com**

ViPs Medicare Systems (VMS) Modifications to Implement the Common Electronic Data Interchange (CEDI) System, Final Implementation (MM6357) (GEN)

MLN Matters Number: MM6357
Related CR Release Date: February 6, 2009
Related CR Transmittal #: R435OTN

Related Change Request (CR) #: 6357
Effective Date: On or before April 6, 2009
Implementation Date: On or before April 6, 2009

Provider Types Affected
Providers and suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 6357 and is informational in nature. CR 6357 implements significant changes in Medicare's systems necessary to prepare for the implementation of the Common Electronic Data Interchange (CEDI) System, a common EDI front end developed to support the DME MACs.

Background
ViPS, the DME MAC shared system maintainer developed and elevated the software changes necessary to remove or disable certain functionality of the electronic data interchange (EDI) front end system; however, the implementation of edits and claims control numbering at the CEDI system has been delayed. This change request prescribes the requirements for ViPs to implement the final changes which will disable all levels of pre-pass editing associated with the Health Insurance Portability & Accountability Act of 1996 HIPAA version of ANSI 837 and 276 transactions, and will discontinue the claim control number (CCN) assignment process for X12 (837 claims only).

The key information for providers and suppliers of DME services are that new editing processes will be put in place for DME claims. These new processes will not change the codes that are transmitted back to you when you submit claims for DME services. These changes only affect how these claims are handled and processed at your DME MAC.

Additional Information
The official instruction, CR 6357, issued to your DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R435OTN.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you have any questions, please contact your 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.

CMS News Flash (GEN)

Flu Season Is Coming! It's not too early to start vaccinating as soon as you receive vaccine. Encourage your patients to get a flu shot as it is still their best defense against the influenza virus. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don't forget, health care workers also need to protect themselves. **Get Your Flu Shot. Not the Flu.** Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professionals and their staff, please go to **http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf** on the CMS Web site. To download the Medicare Part B Immunization Billing quick reference chart, go to **http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf** on the CMS Web site. Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing *Special Edition MLN Matters article* SE0838 **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf** on the CMS Web site.

Suppliers of oxygen and oxygen equipment need to be aware of the procedures for submitting claims for oxygen and oxygen equipment following the enactment of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) on July 15, 2008. Section 144(b) of MIPPA took effect on January 1, 2009, and repeals the requirement for suppliers to transfer title to oxygen equipment to the beneficiary after the 36-month payment cap mandated by the Deficit Reduction Act of 2005. Section 144(b) of MIPPA also establishes new payment rules and supplier responsibilities following the 36-month payment period. See *Medicare Learning Network (MLN) Matters* article number SE0840 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0840.pdf** for additional information about these new rules.

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

The Medicare Patients and Providers Act (MIPPA) of 2008 section 154(b) provides that eligible professionals and other persons are exempt from meeting the September 30, 2009 accreditation deadline that generally applies to other DMEPOS suppliers unless the Centers for Medicare & Medicaid Services (CMS) determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals to whom this exemption applies includes Physicians, Physical Therapists, Occupational Therapists, Qualified Speech-Language Pathologists, Physician Assistants, and Nurse Practitioners. Additionally, section 154(b) of MIPPA allows the Secretary to specify "other persons" that, like the eligible professionals described above, are exempt from meeting the accreditation requirements unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, Medicare is defining "such other persons" as Orthotists, Prosthetists, Opticians, and Audiologists.

The *Adult Immunizations (October 2008) brochure* for health care providers has been updated and is now available in downloadable PDF format from the Centers for Medicare & Medicaid Services *Medicare Learning Network*. This brochure provides an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. To view, download, and print, please go to **http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf** on the CMS Web site.

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.

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

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

Billing Reminder: Pneumatic Compression Devices (PCD) - Coverage and Documentation Requirements (SPE)

PCDs are only covered for beneficiaries who suffer from lymphedema or chronic venous insufficiency with venous stasis ulcers. Unnecessary denials may be avoided by close attention to the coverage and documentation requirements.

LYMPHEDEMA:
Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due to such causes as Milroy's Disease or congenital anomalies. Secondary lymphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as radical surgical procedures with removal of regional groups of lymph nodes (for example, after radical mastectomy), post-radiation fibrosis, and spread of malignant tumors to regional lymph nodes with lymphatic obstruction, among other causes.

Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the patient has undergone a **four-week trial of conservative therapy** and the treating physician determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.

CHRONIC VENOUS INSUFFICIENCY WITH VENOUS STASIS ULCERS:
Chronic venous insufficiency (CVI) of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in the veins. Signs of CVI include hyperpigmentation, stasis dermatitis, chronic edema, and venous ulcers.

Pneumatic compression devices are covered in the home setting for the treatment of CVI of the lower extremities only if the patient has one or more venous stasis ulcer(s) which have failed to heal after a **six month trial of conservative therapy** directed by the treating physician. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb.

DEVICES:
There are four types of devices currently available.

E0650	PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL
E0651	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE
E0675	PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE,FOR ARTERIAL INSUFFICIENCY (UNILATERAL OR BILATERAL SYSTEM)

When a pneumatic compression device is covered, a non-segmented device (E0650) or segmented device without manual control of the pressure in each chamber (E0651) is generally sufficient to meet the clinical needs of the patient. A non-segmented compressor (E0650) with a segmented appliance/sleeve (E0671- E0673) is considered functionally equivalent to an E0651 compressor with a segmented appliance/sleeve (E0667-E0669).

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

A high pressure device (E0675) in not indicated for the treatment of lymphedema or venous insufficiency with stasis ulcers.

DOCUMENTATION:
An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made 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.

A Certificate of Medical Necessity (CMN) which has been completed, signed, and dated by the treating physician must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for a written order if it contains all of the required elements of an order. The CMN for pneumatic compression pumps is CMS Form 846 (DME form 04.04B). The initial claim must include an electronic copy of the CMN.

For all devices, the determination by the physician of the medical necessity of a pneumatic compression device must include:
1) the patient's diagnosis and prognosis;
2) symptoms and objective findings, including measurements which establish the severity of the condition;
3) the reason the device is required, including the treatments which have been tried and failed (prior conservative therapy); and
4) the clinical response to an initial treatment with the device. The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the patient (or caregiver) to apply the device for continued use in the home.

This information should be recorded in the beneficiary's medical record.

If the patient has chronic venous insufficiency with venous stasis ulcers documentation reflecting all of the following must be in the patient's medical record and made available upon request:
1) the location of venous stasis ulcer(s),
2) how long each ulcer has been continuously present,
3) previous treatment with a compression bandage system or compression garment, appropriate dressings for the ulcer(s), exercise and limb elevation for at least the past 6 months,
4) evidence of regular physician visits for treatment of venous stasis ulcer(s) during the past 6 months.

If E0652 is billed, the following additional documentation supporting the medical necessity for this device must be substantiated by information in the patient's medical records and available upon request:
1) the treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode,
2) whether a segmented compressor without calibrated gradient pressure (E0651) or a non-segmented compressor (E0650) with a segmented appliance (E0671-E0673) had been tried and the results,
3) why the features of the device that was provided are needed for this patient,
4) the name, model number, and manufacturer of the device.

Questions pertaining to medical necessity on any form used to gather the above information may not be completed by the supplier or anyone in a financial relationship with the supplier. The information on the form must be supported by documentation in the patient's medical record and made available to the DME MAC upon request.

Refer to the Local Coverage Determination, associated Policy Article and *Supplier Manual* for additional information on coverage and documentation. This article should not be considered a complete substitute for the information contained in those sources.

Elastic Garments - Noncovered (O&P)

CMS has determined that elastic garments do not meet the statutory definition of a brace because they are not rigid or semi-rigid devices. Therefore, effective for claims with dates of service on or after April 1, 2009, these items will be denied as noncovered, no benefit category.

This determination applies to the following HCPCS codes:

L0210 Thoracic rib belt
L1800 Knee orthosis, elastic with stays, prefabricated
L1815 Knee orthosis, elastic or other elastic type material, with condylar pads, prefabricated
L1825 Knee orthosis, elastic knee cap, prefabricated
L1901 Ankle orthosis, elastic, prefabricated
L3651 Shoulder orthosis, single shoulder, elastic, prefabricated
L3652 Shoulder orthosis, double shoulder, elastic, prefabricated
L3700 Elbow orthosis, elastic with stays, prefabricated
L3701 Elbow orthosis, elastic, prefabricated
L3909 Wrist orthosis, elastic, prefabricated
L3911 Wrist hand finger orthosis, elastic, prefabricated

This determination also applies to elastic spinal garments. Currently, both elastic spinal garments and nonelastic spinal orthoses are billed using the same HCPCS codes. The applicable codes are:

L0450 TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated
L0454 TLSO, flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated
L0621 Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated
L0625 Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated
L0628 Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated

Elastic garments may be made of a variety of materials, including but not limited to neoprene or spandex (elastane, Lycra™). They are considered to be elastic even if they have flexible plastic or metal stays. If a garment made with elastic material has a rigid plastic or metal posterior panel, it is considered a nonelastic spinal orthoses for purposes of coverage and coding. A garment that is made primarily of nonelastic material such as cotton or nylon is considered a nonelastic spinal orthosis.

Effective for claims with dates of service on or after April 1, 2009, if a spinal garment billed with one of the preceding HCPCS codes is made primarily of elastic material, the supplier must add the GY modifier to the code and the claim line will be denied as noncovered, no benefit category. If a spinal garment billed with one of the preceding codes is made primarily of nonelastic material (e.g., cotton or nylon) or has a rigid posterior panel, the supplier must add the CG modifier (policy criteria applied) to the code. If the CG or GY modifier is not used with one of the preceding HCPCS codes, it will be rejected/denied as incorrect coding. (Note: The CG and GY modifiers are not used with the rib belts or extremity elastic garments discussed in the first section of this article.)

Information concerning the correct coding of items may be found in the DMECS Product Classification Lists on the Pricing, Data Analysis, and Coding (PDAC) contractor Web site or by contacting the PDAC.

These changes will be incorporated in upcoming revisions of the Ankle-Foot/Knee-Ankle-Foot Orthoses, Knee Orthoses, and Spinal Orthoses medical policies.

Exercise Equipment - Correct Coding (GEN)

Exercise equipment is not considered to be Durable Medical Equipment. According to *CMS Internet Only Manual* 100-2, Ch. 15, §110.1,

> "[p]hysical fitness equipment (such as an exercycle), first-aid or precautionary-type equipment (such as preset portable oxygen units), self-help devices (such as safety grab bars), and training equipment (such as Braille training texts) are considered nonmedical in nature." (**http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf**)

The correct HCPCS Code for exercise items is A9300, Exercise Equipment. Other codes should not be used.

Claims submitted with A9300 will be denied as statutorily noncovered, no benefit category.

Refer to the Pricing, Data Analysis and Coding (PDAC) contractor for information about the correct coding of a specific product.

A product list is maintained in the DMECS database and may be accessed from the PDAC Web site (**https://www.dmepdac.com/dmecsapp/do/search**). The list is updated periodically. Products not listed under A9300 may still be considered exercise equipment, so this is only a partial listing.

PRODUCT	MANUFACTURER	HCPCS CODE
ARTHO-AQUATIC FITNESS SYSTEM	ARTHO-AQUATIC FITNESS SYSTEMS, INC.	A9300
BACK PAC PRO	SAND THERAPEUTIC, INC.	A9300
BANTEX DELUXE PEDAL EXERCISER	AMERICAN BANTEX CORP	A9300
BIO-CUSHION	THOMAS A. TANGLOS	A9300
CAMOPED	OPED, INC.	A9300
CHAMPIOT ARMPOWER	FEREZ INDUSTRIES, INC.	A9300
CREWS-ING CHAIR	CREWS-ING CHAIR CO.	A9300
DYNA-CHAIR	ANTHROS MEDICAL.	A9300
E-Z STEPPER	MIRACLE PRODUCTS, INC.	A9300
EXERCYCLE EXERCISER	EXERCYCLE CORPORATION	A9300
EXODUS I	GENESIS CHAIRS, INC.	A9300
EXODUS II	GENESIS CHAIRS, INC.	A9300
FACIAL-FLEX ADULT	FACIAL-FLEX CORPORATION	A9300
FACIAL-FLEX PEDIATRIC	FACIAL-FLEX CORPORATION	A9300
FIT-BACK SPINE CARE SYSTEM	FIT-BACK (NU-BACK, LLC)	A9300
FLEXICISER	FLEXICISER INTERNATIONAL	A9300
FLEXXZOR	MEDICAL DEVICES, INC.	A9300
GENUBENDER	INNOVATIVE INTUITION, INC.	A9300
KNEE/ANKLE MOBILIER	HAYES KAM SYSTEMS	A9300
MACBLOCKER	UNIQUE REHAB SOLUTIONS, INC.	A9300
MASTERCARE BACK-A-TRACTION	SWEDISH BACKCARE SYSTEM, INC.	A9300
MAXM DORSI FLEXION HARNESS	MEDREP, INC.	A9300
MAXM KNEE EXTENSION HARNESS	MEDREP, INC.	A9300
MAXM PRONE FLEXION HARNESS	MEDREP, INC.	A9300

MAXM SEATED FLEXION HARNESS	MEDREP, INC.	A9300
MOTORIZED BICYCLE EXERCISE TRAINER	OZMARK SYSTEMS MANUFACTURING, LLC	A9300
PETTIBON LINKED EXERCISE TRAINER	THE PETTIBON SYSTEM	A9300
PHLEBO PUMP	PREVENT PRODUCTS	A9300
SOLOCISER	A-BAR TECHNOLOGY INC.	A9300
SOLOHAND	BEARFOOT FOOT CRADLE	A9300
SPI-RISE	S.D.R., INC.	A9300
THERA PEDAL ARM AND LEG CYCLE	THERAPEUTIC DESIGNS, INC.	A9300
UE RANGER	REHAB INNOVATIONS, INC.	A9300
WHEELCHAIR BIKE PLUS+	CHIEFS MANUFACTURING COMPANY	A9300

HCPCS Code Update - 2009 (GEN)

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2009.

Added Codes/Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2009.

Discontinued Codes/Modifiers: Codes or modifiers that are discontinued will continue to be valid for claims with dates of service on or before December 31, 2008, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2009.

There is no grace period that would allow submission of the discontinued code for dates of service in 2009.

Narrative Changes: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2009.

The appearance of a code in this list does not necessarily indicate coverage.

Ankle-Foot and Knee-Ankle-Foot Orthoses

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L4360	WALKING BOOT, PNEUMATIC, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
L2860	ADDITION TO LOWER EXTREMITY JOINT, KNEE OR ANKLE, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM, EACH	NONE

Intravenous Immune Globulin

	Added Code
Code	**Narrative**
J1459	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
J1572	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA/FLEBOGAMMA DIF), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	INJECTION, IMMUNE GLOBULIN, (FLEBOGAMMA), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
Q4097	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), 500 MG	J1459

Lower Limb Prostheses

	Discontinued Codes	
Code	**Narrative**	**Crosswalk to Code**
L5993	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, FOOT ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)	NONE
L5994	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, KNEE ONLY, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)	NONE
L5995	ADDITION TO LOWER EXTREMITY PROSTHESIS, HEAVY DUTY FEATURE, OTHER THAN FOOT OR KNEE, (FOR PATIENT WEIGHT GREATER THAN 300 LBS)	NONE

Miscellaneous

	Added Codes
Code	**Narrative**
A9284	SPIROMETER, NON-ELECTRONIC, INCLUDES ALL ACCESSORIES *(Not covered; no benefit category)*
E0487	SPIROMETER, ELECTRONIC, INCLUDES ALL ACCESSORIES *(Not covered; no benefit category)*
E0770	FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED
L0113	CRANIAL CERVICAL ORTHOSIS, TORTICOLLIS TYPE, WITH OR WITHOUT JOINT, WITH OR WITHOUT SOFT INTERFACE MATERIAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

L6711	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC
L6712	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC
L6713	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC
L6714	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC
L6721	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED
L6722	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED

	Discontinued Codes	
Code	**Narrative**	**Crosswalk to Code**
L3890	ADDITION TO UPPER EXTREMITY JOINT, WRIST OR ELBOW, CONCENTRIC ADJUSTABLE TORSION STYLE MECHANISM, EACH	NONE
L7611	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	L6711
L7612	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED, PEDIATRIC	L6712
L7613	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, PEDIATRIC	L6713
L7614	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, PEDIATRIC	L6714
L7621	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	L6721
L7622	TERMINAL DEVICE, HOOK OR HAND, HEAVY DUTY, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE, LINED OR UNLINED	L6722

Nebulizers

	Added Code
Code	**Narrative**
J7606	FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
Q4099	FORMOTEROL FUMARATE, INHALATION SOLUTION, FDA APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS	J7606

Oxygen and Oxygen Equipment

	Added Codes
Code	**Narrative**
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1356	OXYGEN ACCESSORY, BATTERY PACK/CARTRIDGE FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1357	OXYGEN ACCESSORY, BATTERY CHARGER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1358	OXYGEN ACCESSORY, DC POWER ADAPTER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH

Pneumatic Compression Devices

	Added Codes
Code	**Narrative**
E0656	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, TRUNK
E0657	SEGMENTAL PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, CHEST

Power Mobility Devices

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
K0899	POWER MOBILITY DEVICE, NOT CODED BY SADMERC OR DOES NOT MEET CRITERIA	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA

Surgical Dressings

	Added Code
Code	**Narrative**
A6545	GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE, 30-50 MM HG, EACH

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A6010	COLLAGEN BASED WOUND FILLER, DRY FORM, PER GRAM OF COLLAGEN	COLLAGEN BASED WOUND FILLER, DRY FORM, STERILE, PER GRAM OF COLLAGEN
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM OF COLLAGEN	COLLAGEN BASED WOUND FILLER, GEL/PASTE, STERILE, PER GRAM OF COLLAGEN
A6021	COLLAGEN DRESSING, PAD SIZE 16 SQ. IN. OR LESS, EACH	COLLAGEN DRESSING, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH

A6022	COLLAGEN DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH
A6023	COLLAGEN DRESSING, PAD SIZE MORE THAN 48 SQ. IN., EACH	COLLAGEN DRESSING, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH
A6024	COLLAGEN DRESSING WOUND FILLER, PER 6 INCHES	COLLAGEN DRESSING WOUND FILLER, STERILE, PER 6 INCHES
A6196	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING
A6197	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6198	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING
A6199	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, PER 6 INCHES	ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND FILLER, STERILE, PER 6 INCHES
A6203	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	COMPOSITE DRESSING, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6204	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	COMPOSITE DRESSING, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6205	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	COMPOSITE DRESSING, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6206	CONTACT LAYER, 16 SQ. IN. OR LESS, EACH DRESSING	CONTACT LAYER, STERILE, 16 SQ. IN. OR LESS, EACH DRESSING
A6207	CONTACT LAYER, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	CONTACT LAYER, STERILE, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6208	CONTACT LAYER, MORE THAN 48 SQ. IN., EACH DRESSING	CONTACT LAYER, STERILE, MORE THAN 48 SQ. IN., EACH DRESSING
A6209	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

A6210	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6211	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6212	FOAM DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6213	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6214	FOAM DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	FOAM DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6215	FOAM DRESSING, WOUND FILLER, PER GRAM	FOAM DRESSING, WOUND FILLER, STERILE, PER GRAM
A6219	GAUZE, NON-IMPREGNATED, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6220	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6221	GAUZE, NON-IMPREGNATED, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6222	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6223	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, STERILE, PAD SIZE MORE THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING

A6224	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED WITH OTHER THAN WATER, NORMAL SALINE, OR HYDROGEL, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6228	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6229	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6230	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	GAUZE, IMPREGNATED, WATER OR NORMAL SALINE, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6231	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING
A6232	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE GREATER THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, STERILE, PAD SIZE GREATER THAN 16 SQ. IN., BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6233	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING	GAUZE, IMPREGNATED, HYDROGEL, FOR DIRECT WOUND CONTACT, STERILE, PAD SIZE MORE THAN 48 SQ. IN., EACH DRESSING
A6234	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6235	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6236	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6237	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING

A6238	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6239	HYDROCOLLOID DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROCOLLOID DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6240	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, PER FLUID OUNCE	HYDROCOLLOID DRESSING, WOUND FILLER, PASTE, STERILE, PER OUNCE
A6241	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, PER GRAM	HYDROCOLLOID DRESSING, WOUND FILLER, DRY FORM, STERILE, PER GRAM
A6242	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING
A6243	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6244	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6245	HYDROGEL DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6246	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6247	HYDROGEL DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	HYDROGEL DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE	HYDROGEL DRESSING, WOUND FILLER, GEL, STERILE, PER FLUID OUNCE
A6251	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

A6252	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6253	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING
A6254	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6255	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6256	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING	SPECIALTY ABSORPTIVE DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 48 SQ. IN., WITH ANY SIZE ADHESIVE BORDER, EACH DRESSING
A6257	TRANSPARENT FILM, 16 SQ. IN. OR LESS, EACH DRESSING	TRANSPARENT FILM, STERILE, 16 SQ. IN. OR LESS, EACH DRESSING
A6258	TRANSPARENT FILM, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING	TRANSPARENT FILM, STERILE, MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING
A6259	TRANSPARENT FILM, MORE THAN 48 SQ. IN., EACH DRESSING	TRANSPARENT FILM, STERILE, MORE THAN 48 SQ. IN., EACH DRESSING
A6260	WOUND CLEANSERS, ANY TYPE, ANY SIZE	WOUND CLEANSERS, STERILE, ANY TYPE, ANY SIZE
A6261	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT ELSEWHERE CLASSIFIED	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED
A6262	WOUND FILLER, DRY FORM, PER GRAM, NOT ELSEWHERE CLASSIFIED	WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED
A6266	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, ANY WIDTH, PER LINEAR YARD	GAUZE, IMPREGNATED, OTHER THAN WATER, NORMAL SALINE, OR ZINC PASTE, STERILE, ANY WIDTH, PER LINEAR YARD
A6407	PACKING STRIPS, NON-IMPREGNATED, UP TO 2 INCHES IN WIDTH, PER LINEAR YARD	PACKING STRIPS, NON-IMPREGNATED, STERILE, UP TO 2 INCHES IN WIDTH, PER LINEAR YARD

Wheelchair Options/Accessories

	Added Codes
Code	**Narrative**
E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM
E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATED MOVEMENT OF MULTIPLE POSITIONING FEATURES

Wheelchair Seating

	Added Code
Code	**Narrative**
E2231	MANUAL WHEELCHAIR ACCESSORY, SOLID SEAT SUPPORT BASE (REPLACES SLING SEAT), INCLUDES ANY TYPE MOUNTING HARDWARE

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
K0669	WHEELCHAIR ACCESSORY, WHEELCHAIR SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM SADMERC	WHEELCHAIR ACCESSORY, WHEELCHAIR SEAT OR BACK CUSHION, DOES NOT MEET SPECIFIC CODE CRITERIA OR NO WRITTEN CODING VERIFICATION FROM DME PDAC

Modifiers

	Added Modifiers
Modifier	**Narrative**
KE	BID UNDER ROUND ONE OF THE DMEPOS COMPETITIVE BIDDING PROGRAM FOR USE WITH NON-COMPETITIVE BID BASE EQUIPMENT
RA	REPLACEMENT OF A DME ITEM
RB	REPLACEMENT OF A PART OF DME FURNISHED AS PART OF A REPAIR

	Discontinued Modifier
Modifier	**Narrative**
RP	REPLACEMENT AND REPAIR -RP MAY BE USED TO INDICATE REPLACEMENT OF DME, ORTHOTIC AND PROSTHETIC DEVICES WHICH HAVE BEEN IN USE FOR SOMETIME. THE CLAIM SHOWS THE CODE FOR THE PART, FOLLOWED BY THE 'RP' MODIFIER AND THE CHARGE FOR THE PART.

	Narrative Changes
Modifier	**Narrative**
KL	DMEPOS ITEM DELIVERED VIA MAIL

LCD and Policy Article Revisions Summary for March 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: 04/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: L1901 from code range of AFO-KAFO used with ambulation.

HCPCS CODES AND MODIFIERS:

Revised: Code L4360 descriptor.

Deleted: Code L2860.

Policy Article

Revision Effective Date: 04/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Noncoverage language for elastic support garments.

CODING GUIDELINES:

Deleted: Code L1901 from the prefabricated orthoses list and from the from ankle-foot orthosis worn by ambulatory patients.

Added: Code L2770 is invalid.

Revised: Removed Column I/Column II table in lieu of statement about billing replacement codes at time of initial issue.

Revised: SADMERC to PDAC.

Knee Orthoses

LCD

Revision Effective Date: 04/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

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

Deleted: Codes L1800, L1815, L1825 from prefabricated knee orthoses.

Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Eligible for Separate Payment.

Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Not Medically Necessary.

HCPCS CODES AND MODIFIERS:

Revised: KX modifier.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

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

DOCUMENTATION:

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

Revised: Changed DMERC to DME MAC.

Policy Article

Revision Effective Date: 04/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Deleted: Codes L1800, L1815, L1825 from the reasonable useful lifetime chart.

Added: Noncoverage language for elastic support garments.

CODING GUIDELINES:

Deleted: Codes L1800, L1815, L1825 from Base code & Addition Codes - Not Separately Payable.

Deleted: Code L2860.

Revised: SADMERC to PDAC.

Spinal Orthoses: TLSO and LSO
LCD
Revision Effective Date: 04/01/2009
HCPCS CODES AND MODIFIERS:
Added: CG, GY
DOCUMENTATION REQUIREMENTS:
Added: Use of CG and GY modifiers with elastic spinal orthoses.

Policy Article
Revision Effective Date: 04/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Statement concerning noncoverage of elastic spinal orthoses.
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Wheelchair Options and Accessories
LCD
Revision Effective Date: 01/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Changed: Terminology from Assistive Technology Supplier/ Practitioner to Assistive Technology Professional.
HCPCS CODES AND MODIFIERS:
Added: E2230, E2295 (to Miscellaneous Accessories section), RB modifier.
Revised: KX modifier.
Deleted: RP modifier.

Policy Article
Revision Effective Date: 01/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Noncoverage statement for E2230.
CODING GUIDELINES:
Replaced: RP with RB modifier and revised instructions.
Revised: Billing instructions for bilateral items.
Changed: References from SADMERC to PDAC.
Changed: Statement concerning E0968, E1228 to indicate that they are invalid for claim submission.
Added: E2373 to instructions for KC modifier.

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

LCD and Policy Article Revisions - Summary for December 18, 2008 (GEN)

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

Patient Lifts

LCD

Revision Effective Date:01/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: Least costly alternative statement for E0635.
Revised: Coverage criteria for E0636.
Added: Coverage criteria for E0639 and E0640.

DOCUMENTATION REQUIREMENTS:

Added: KX modifier requirement for E0636.

Policy Article

Revision Effective Date:01/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Deleted: Noncoverage statement for E0639, E0640.
Added: Noncoverage statement about home modifications.
Revised: E0625 noncoverage statement.

CODING GUIDELINES:

Added: Definition for E0636, E0639, and E0640.
Revised: Definition of E1035.
Added: Requirement for PDAC coding verification review for E0636, E0639, E0640, and E1035.
Reformatted bundling table.
Added E0639 and E0640 to table.
Changed: SADMERC to PDAC.

Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea

LCD

Revision Effective Date: 01/01/2009 except where noted otherwise in the LCD.

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Criteria for Type IV home sleep test device.
Added: Coverage requirements for beneficiaries enrolling in Medicare and needed replacement PAP device and/or accessories.

DOCUMENTATION:

Added: Requirements for beneficiaries enrolling in Medicare and needed replacement PAP device and/or accessories.

APPENDICES:

Added: List of approved Type IV devices that do not report AHI/RDI based on direct measurement of airflow or thoracoabdominal movement.
Covered Type IV device list to include WatchPAT devices.

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.*

Oxygen - Certificates of Medical Necessity - Replacement Equipment (OXY)

On January 1, 2009 CMS implemented statutory provisions defining a new payment policy for home oxygen. Payment for oxygen equipment is now made for a 36-month rental period. The supplier retains title to the equipment at the end of this rental period but is required to continue to provide the oxygen equipment and contents (when applicable) for the duration of the 5 year reasonable useful lifetime (RUL) of the oxygen equipment. Multiple recent publications have addressed the details of the new payment policy. This article addresses the use of the Oxygen Certificate of Medical Necessity (CMN) in processing oxygen claims.

There are four general situations in which a new 36-month rental period is begun. In all of these situations a new Initial CMN is required:

1. Initial use of home oxygen.

2. Resumption of use of home oxygen when there has been a break in the medical necessity of oxygen (break-in-need) during the 36-month rental period, for at least 60 days plus the days remaining in the last paid rental month. (Note A: A break-in-billing/Part B payment [e.g., due to a hospital or nursing facility stay or enrollment in a Medicare HMO] does not begin a new 36-month rental period if use of oxygen continues during that time.) (Note B: During the time from the end of the 36-month rental period to the end of the RUL for the equipment, a new 36-month rental period does not start for either a break-in-need or a break in billing/Part B payment.)

3. Replacement because the RUL of prior equipment has been reached.

4. Replacement because of irreparable damage, theft, or loss of equipment. (Note C: Irreparable damage refers to a specific accident or to a natural disaster [e.g., fire, flood]. Irreparable damage does not refer to wear and tear over time.)

For situations 1 and 2, the requirements for an Initial, Recertification, and Revised CMNs that are stated in the current Oxygen and Oxygen Equipment local coverage determination (LCD) apply. However, for situations 3 and 4, there are some differences in the requirements related to the Initial and Recertification CMNs. There are no differences with respect to Revised CMNs.

I. Initial CMN (for replacement equipment)

- Initial Date should be the date that the replacement equipment is initially needed. This is generally understood to be the date of delivery of the oxygen equipment.
- Blood gas study. Repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN. (Suppliers are reminded that in an audit they may be asked to provide a copy of the actual test report to verify that coverage criteria have been met.)
- Physician visit. There is no requirement for a physician visit that is specifically related to the completion of the CMN.

II. Recertification CMN (for replacement equipment)

- Recertification Date should be 12 months following the Initial Date when the value on the Initial CMN (for the replacement equipment) meets Group I criteria or 3 months following the Initial Date when the qualifying blood gas value on the Initial CMN meets the Group II criteria. (Note: The Initial Date [for the replacement equipment] should be entered on the Recertification CMN.)
- Blood gas study. Same instructions as for the Initial CMN for the replacement equipment.
- Physician visit. Same instructions as for the Initial CMN for the replacement equipment.

Suppliers are reminded that a written order is required when replacing equipment. The CMN may act as a substitute for a written order if it meets the requirements for a detailed written order.

Claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss. The RA modifier is not used when billing for a new initial following a 60+ day break in need.

These changes will be incorporated in a future revision of the Oxygen LCD. For additional information on the use of CMNs refer to the *Supplier Manual* and the Oxygen and Oxygen Equipment LCD.

Positive Airway Pressure (PAP) Devices - Important Information for the Ordering Physician December 2008 (SPE)

Dear Physician,

On March 13, 2008, CMS released a revised National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) devices. In September 2008, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) published a revised Local Coverage Determination (LCDs) and a "Dear Physician" letter which reviewed the pertinent coverage criteria for these devices, including bi-level positive airway pressure devices (respiratory assist devices, RADs) when they are use to treat obstructive sleep apnea (OSA).

The DME MAC medical directors have updated the PAP LCD; consequently, we are republishing this important information for ordering physicians. In addition, there are Frequently Asked Questions (FAQs) specifically addressing issues of importance to ordering physicians on the DME MAC Web sites.

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

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

2) The patient must have a facility based polysomnogram or a Type II, III, or IV home sleep study. Type IV home sleep studies are acceptable when performed by devices that either directly or indirectly allow calculation of an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI). Devices that allow direct calculation of AHI/RDI by measuring airflow or thoracoabdominal movement are acceptable. The only currently acceptable Type IV device that indirectly allows calculation of an AHI/RDI are the Watch-PAT devices (Itamar Medical), effective for tests conducted on or after January 1, 2009. Acceptable indirect measurement products are listed in the LCD.

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

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

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

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

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

6) For beneficiaries who received a PAP device prior to FFS Medicare enrollment and are now enrolled in Medicare and are seeking a new PAP device and/or accessories, both of the following coverage requirements must be met:
   a. Sleep test - There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, 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,
   b. 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:
      i. The beneficiary has a diagnosis of obstructive sleep apnea; and,
      ii. The beneficiary continues to use the PAP device.

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

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

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

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Positive Airway Pressure (PAP) Devices - Physician Frequently Asked Questions - December 2008 (SPE)

Based on questions received from the clinical community, the following Frequently Asked Questions will address issues in the Positive Airway Pressure (PAP) Devices local coverage determination (LCD). The complete medical policy may be viewed on the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) individual Web sites or in the CMS Medicare Coverage Database. Note that the formal title of the policy is Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. The Web address of the Medicare Coverage Database is: **http://www.cms.hhs.gov/mcd/search.asp**. Additional information may also be found in the "Dear Physician" letter published in December 2008 on the DME MAC Web sites.

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

Ordering/Treating Physician Issues

1. **Question:** Explain the physician visits required for patients who are being evaluated for sleep disordered breathing.

   Answer: Two face-to-face evaluations are required for a patient to be considered for Medicare coverage for PAP therapy. There must be a face-to-face visit with the treating physician prior to ordering of any sleep test. This should generally include documentation in the patient's medical record the following elements:
   a) Sleep history and symptoms
   b) Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory
   c) Pertinent physical examination - e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam

   Medicare coverage is conditional for the first 3 months. Continued coverage beyond the first 3 months is contingent upon demonstration of benefit from the use of a PAP device. Therefore, following the sleep test the patient must see the treating physician again, sometime between the 31st and 91st day, to document improvement of the patient's symptoms. In addition, the physician must review data from the PAP device which documents use at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.

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

   Answer: 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.

3. **Question:** 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?

   Answer: 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.

4. **Question:** Can a registered nurse (RN) conduct the follow-up evaluation?

   Answer: No, the treating physician (defined and discussed above) must be directly involved in the follow-up evaluation.

5. **Question:** 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.

   Answer: 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.

6. **Question:** 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?

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

7. **Question:** Is there a time limit from initial face-to-face evaluation to the sleep study?

   Answer: 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.

8. **Question:** Can the face-to-face evaluation be done after the sleep test or after initiation of PAP therapy and will that meet the LCD documentation requirements?

   Answer: 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.

9. **Question:** If a patient is put on a respiratory assist device (RAD) device with less than 30 days 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.

   Answer: 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.

10. **Question:** What happens if the patient does not get in to see the treating physician within the 31st-91st day?

    Answer: If the patient does not get in to see the treating physician for the re-evaluation between the 31st and 91st day of PAP treatment, coverage of the PAP device will end after 3 months. If the physician performs the re-evaluation at a later date, coverage would resume on the date of the re-evaluation. The patient may be responsible for payment of the device and accessories during the intervening time period between the end of the third month and whenever the re-evaluation takes place.

11. **Question:** What is required for patients who may have received their PAP device from a private insurer and are now enrolled in fee for service (FFS) Medicare? What is needed for those patients to get a new device and/or supplies?

    Answer: 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 enrollment, 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.

Sleep Test

12. Question: The LCD notes that Type IV devices that do not directly measure airflow or thoracoabdominal movement to calculate an AHI/RDI will be considered for coverage after evaluation of the medical literature. Are there any Type IV devices that meet the requirements for coverage? If so, where can we find this list?

Answer: The DME MAC medical directors have received information regarding Watch-PAT.. After review of the scientific literature, these devices have been added to the local coverage determination (LCD) as a covered Type IV device, effective for tests conducted with dates of service on or after January 1, 2009. The LCD also now includes in the Appendices a list of Type IV devices approved for coverage that indirectly measure AHI/RDI. This coverage expansion will be reflected in an upcoming policy revision.

13. Question: Who is allowed to interpret home sleep tests?

Answer: If a home sleep study is performed after November 1, 2008, it must be interpreted by a physician who holds either:

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

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

14. Question: What if my local Part A or Part B contractor has an LCD for polysomnography that is different from the DME MAC LCD. Which one applies?

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

Adherence Monitoring

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

Answer: The LCD was revised to include allowance for visual inspection, in addition to direct download of information from the PAP device. Visual inspection means determining adherence by looking at information on the PAP device's display screen and documenting the values in a written report. The medical equipment supplier is allowed to contact the beneficiary via telephone or during an in-person visit and ask them to read values from their device. Alternatively, the physician may read the values during a home/office visit and document the adherence information in the patient's medical record. 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.

16. Question: Can the report be based on 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."

Answer: 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 ≥ 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.

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

    Answer: 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 ≥ 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.

18. **Question:** Some devices report 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. Can this device and still meet the adherence requirement?

    Answer: 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 or physician 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.

19. **Question:** Must adherence as defined in the LCD continue to be documented after the initial 3 month period?

    Answer: No. Following the initial 3 month trial and documentation of use ≥4 hrs. per night on 70% of nights in a 30 consecutive day period, the medical equipment supplier can document continued use of the device. This may be accomplished via documentation of attestation by the beneficiary.

Positive Airway Pressure (PAP) Devices - Supplier Frequently Asked Questions - December 2008 (SPE)

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

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

   Answer: 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.

2. **Question:** 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?

Answer: 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.

3. **Question:** Can a registered nurse (RN) conduct the follow-up evaluation?

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

4. **Question:** 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.

   Answer: 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

5. **Question:** 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?

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

6. **Question:** Is there a time limit from initial face-to-face evaluation to the sleep study?

   Answer: 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

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

   Answer: 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.

8. **Question:** 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."

   Answer: 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 ≥ 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.

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

   Answer: 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 ≥ 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.

10. **Question:** 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?

    Answer: 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.

11. **Question:** Must suppliers continue to document adherence as defined in the LCD after the initial 3 month period?

    Answer: No. Following the initial 3 month trial and documentation of use ≥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

12. **Question:** 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?

    Answer: 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).

13. **Question:** 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?

    Answer: 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.

14. Question: 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?

Answer: 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."

15. Question: If a patient is put on a respiratory assist device (RAD) with less than 30 days 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.

Answer: 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.

16. Question: 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?

Answer: No, an ABN provided prior to the dispensing of the device that advises the beneficiary of a specific reason(s) why Medicare may deny coverage would not be considered a "blanket" ABN. Alternatively, an ABN may also be obtained in the month prior to a subsequent rental month when the supplier learns that the beneficiary will no longer meet Medicare coverage requirements.

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

Answer: 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.

18. Question: 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?

Answer: 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.

Repair Labor Billing and Payment Policy (MOB)

Effective for dates of service on or after April 1, 2009, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are instituting a billing and payment policy for common repairs based on standardized labor times. This applies to non-rented and out-of-warranty items. This effective date coincides with the effective date of the new code for repairs for non-oxygen equipment - K0739 (REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT OTHER THAN OXYGEN REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES). One unit of service = 15 minutes. Code E1340 is no longer valid for repairs for dates of service on or after April 1, 2009.

The following table contains repair units of service allowances for commonly repaired items. Units of service include basic troubleshooting and problem diagnosis. Suppliers are reminded that there is no Medicare payment for travel time or equipment pick-up and/or delivery.

Type of Equipment	Part Being Repaired/Replaced	Allowed Units of Service (UOS)
Power Wheelchair	Batteries (includes cleaning and testing)	2
Power Wheelchair	Joystick (includes programming)	2
Power Wheelchair	Charger	2
Power Wheelchair	Drive wheel motors (single/pair)	2/3
Power or Manual Wheelchair	Wheel/Tire (all types, per wheel)	1
Power or Manual Wheelchair	Armrest or armpad	1
Power Wheelchair	Shroud/cowling	2
Manual Wheelchair	Anti-tipping device	1
Hospital Bed	Pendant	2
Hospital Bed	Headboard/footboard	2
CPAP	Blower Assembly	2
Seat Lift	Hand Control	2
Seat Lift	Scissor mechanism	3
Patient Lift	Hydraulic Pump	2

Suppliers may only bill the allowable units of service listed in the above table for each repair, regardless of the actual repair time. Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Suppliers are also reminded that Medicare does not pay for repairs to capped rental items during the rental period or items under warranty.

Supplies and Accessories Used With Beneficiary Owned Equipment (MOB)

Effective for claims submitted on or after April 1, 2009, for supplies and accessories to be used with beneficiary-owned equipment, all of the following information must be submitted 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 of whether the patient owns the equipment that requires the part or supply.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, should the supply or accessory have additional, separate criteria, they must be met also. In the event of an audit or claim appeal, 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.

Surgical Dressings Billing Instruction for HCPCS Code A6545 (SPE)

Recent revisions to the Local Coverage Determination (LCD) for Surgical Dressings and the related Policy Article were published with an effective date of January 1, 2009. The Policy Article revision neglected to include billing instructions for HCPCS Code A6545.

A6545 GRADIENT COMPRESSION WRAP, NON-ELASTIC, BELOW KNEE 30-50 MM HG, EACH

Similar to codes A6531 and A6532 (compression stockings) which are addressed in the Policy Article Coding Guidelines section, HCPCS modifiers A1-A9 are not to be used with A6545.

When a gradient compression wrap, A6545, is used for an open venous stasis ulcer, the code must be billed with the AW modifier. If there is no open ulcer, the AW modifier must not be used. Claims for code A6545 without an AW modifier will be denied as statutorily noncovered.

The right (RT) and left (LT) modifiers must also be used with this code. When the same code for bilateral items (left and right) is billed on the same date of service, bill both items on the same claim line using LTRT modifiers and 2 units of service.

These guidelines will be included in a future revision of the Surgical Dressings medical policy.

The only products that may be billed with code A6545 (non-elastic compression wrap) are those which have received a written Coding Verification Review from the Pricing, Data Analysis, and Coding (PDAC) contractor and that are posted in the Product Classification List on the PDAC Web site.

Suppliers should refer to the Surgical Dressings LCD and related Policy Article for additional guidance on the coverage, coding and documentation requirements.

Therapeutic Shoes for Diabetics - Physician Documentation Requirements (O&P)

Dear Physician,

Medicare covers therapeutic shoes and inserts for persons with diabetes. This statutory benefit is limited to one pair of shoes and up to 3 pairs of inserts or shoe modifications per calendar year. However, in order to qualify, the Medicare statute mandates specific coverage and documentation requirements that must be met.

The need for therapeutic shoes must be certified by a physician who is an M.D. or D.O. and who has the primary responsibility for treating the patient's systemic diabetes. This physician must:

1. Document in the patient's medical record that the patient has diabetes; and
2. Certify that the patient is being treated under a comprehensive plan of care for diabetes, and that the patient needs diabetic shoes; and
3. Document in the patient's medical record the presence of one or more of the following conditions:
    a. Previous amputation of the other foot, or part of either foot, or
    b. History of previous foot ulceration of either foot, or
    c. History of pre-ulcerative calluses of either foot, or
    d. Peripheral neuropathy and evidence of callus formation of either foot, or
    e. Foot deformity of either foot, or
    f. Poor circulation (i.e., small or large vessel arterial insufficiency) in either foot.

A new certification statement, signed and dated by the treating physician, must be provided on a yearly basis in order to obtain a new pair of shoes or inserts.

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient's diabetes and that one of the conditions listed in 3a - 3f is present. If requested by the supplier, you must provide copies of those records.

As with all items covered by Medicare, there must be a detailed written order for the items that are provided. The specifics of what is being provided may be entered by the supplier, but the physician must sign and date the order. Signature or date stamps are not acceptable. A new order is required yearly.

Although the requirements listed in 1-3 above must be documented by the M.D. or D.O. who has the primary responsibility for treating the patient's diabetes, the order could be provided by that physician or by a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

Physicians can review the complete Local Coverage Determination and Policy Article titled Therapeutic Shoes for Persons with Diabetes on the DME MAC A Web site at **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**. It may also be viewed in the national Medicare Coverage Database at **http://www.cms.hhs.gov/mcd/overview.asp**.

Physicians are reminded that in order for these items to be reimbursed for your patients, the DME supplier will need to collect the medical documentation described above. Providing this documentation is in compliance with the HIPPA Privacy Rule. Also note that you may not charge the supplier or the beneficiary to provide this information. Please cooperate with the supplier so that they can provide the therapeutic shoes and inserts that are needed by your patient.

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

Wide Spread Quarterly Review Results - Glucose Supplies HCPCS A4253, A4258, A4259 (SPE)

The Jurisdiction A Medical Review department recently completed a widespread Prepay probe for Glucose Supplies covering HCPCS codes A4253, A4258 and A4259. A widespread pre pay probe is a selection of claims reviewed for medical necessity based on a particular service from multiple suppliers.

This review was conducted from August through December 2008. A total of 17,988 claims were reviewed. Of the claims reviewed, 65.14% were denied. The following are the most common reasons for denial:

- Duplicate denials caused by:
  - Overlapping dates of service by different suppliers
  - Overlapping dates of service by the same suppliers
  - Suppliers changing their dates of service
  - Suppliers changing their billing frequency

- LCD related denials:
  - Suppliers billing in excess of the usual policy amounts without sufficient information from the medical record to provide justification
  - Missing or incorrect prescriptions

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

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

Join the Jurisdiction A DME MAC at the 2009 Spring Medtrade (GEN)

The 2009 Spring Medtrade Conference and Exposition will be held March 25-26, at the Las Vegas Convention Center in Las Vegas, Nevada.

Medicare Contractors, including staff from each of the four Durable Medical Equipment Medicare Administrative Contractors (DME MACs), National Supplier Clearinghouse (NSC), Common Electronic Data Interchange (CEDI) contractor, and the Competitive Bidding Implementation Contractor (CBIC), will be among the many exhibitors available to provide information and address questions. Make sure to visit the Medicare Contractors at **booth number 932**. The DME MAC Provider Outreach & Education staff will also provide a one-hour "*Medicare Updates*" presentation on March 26th from 9:45 - 10:45am.

For more information about the Medtrade Conference and Exposition, visit the Web site at:
http://www.medtrade.com

New DME MAC Jurisdiction A Self-Service Calculator Tools - Coming Soon (GEN)

The DME MAC Jurisdiction A Provider Outreach & Education Team is excited to announce several new self-service calculator tools that have been developed to assist you in determining appropriate time related deadlines. With these self-service tools, you provide a beginning date and our calculators will do the math.

The following self-service calculators will be available first:

- **Redetermination Request Calculator** - developed to assist in determining timely filing deadlines to request a redetermination
- **Claim Filing Calculator** - developed to assist in determining timely filing deadlines for claim submission
- **Capped Rental 13th Month Calculator** - developed to assist in determining the 13th month for a capped rental item
- **Oxygen Rental 36th Month Calculator** - developed to assist in determining the 36th month for an oxygen rental

Additional self-service calculator tools are under development and will be implemented in the near future. Check the "*Billing Support*" section of the DME MAC A Web site for the addition of more self-service calculators.

Oxygen and Oxygen Equipment Changes Resources (GEN)

DME MAC Jurisdiction A has created a new section of our *Highlights and Headlines* Web page dedicated to the changes currently affecting oxygen and oxygen equipment.

This new section contains links to resources on the following topics: 36-month rental period, replacement of equipment, reasonable useful lifetime, continuous use, proof of delivery, contents and much more.

The section will continually be updated as new information is released.

Revised ABN Form Mandated for Use Effective March 1, 2009 (GEN)

CMS introduced and implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131) effective March 3, 2008. Since that time, CMS permitted a dual acceptability period allowing use of the old version, or the revised version, of the form until suppliers became better acclimated to the changes.

On **March 1, 2009**, notifiers were required to begin using the revised ABN (CMS-R-131) for all situations applicable to ABN use. CMS will no longer accept any previous version of this form.

The form and notice instructions are posted on the CMS Beneficiary Notice Initiative Web page at:
http://www.cms.hhs.gov/bni

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 Monday, March 23, 2009. The focus will be on **recent modifier additions and changes**. 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.

Signature and Date Stamp Reminder (GEN)

CMS clarified in SE0829 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0829.pdf**), dated July 29, 2008, that signature stamps are no longer acceptable on any medical records. This change was implemented based on *Program Integrity Manual* revisions included in CR5971 (**http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf**). The *Program Integrity Manual* states:

"Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes."

Additionally, CMS has clarified in MM6261 (**http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6261.pdf**) that signature and date stamps are no longer acceptable on CMNs and DIFs. The effective date for this change was February 02, 2009.

Test Your Knowledge Quiz Reminder (GEN)

To continue to enhance 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 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:
During the first quarter of 2009 chapters 1 and 3 of the *Supplier Manual* were updated. Chapter 3 was updated to include an interactive CMS-1500 form. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

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

For Your Notes

Please 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:
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LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

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

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Visit the following Web sites for more information:

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

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

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