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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Billing/Finance

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

2009 Durable Medical Equipment Prosthetics, Orthotics, and Supply (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Codes Jurisdiction List (MM6522) (GEN)

MLN Matters® Number: MM6522
Related CR Release Date: July 10, 2009
Related CR Transmittal #: R1765CP
Related Change Request (CR) #: 6522
Effective Date: August 10, 2009
Implementation Date: August 10, 2009

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

Impact on Providers
This article is informational and is based on Change Request (CR) 6522 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC, Part B 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 *2009 Jurisdiction List* is an Excel® spreadsheet and is available at **http://www.cms.hhs.gov/center/dme.asp** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Additional Information
To see the official instruction (CR6522) issued to your Medicare DME MAC, carrier, or A/B MAC, visit **http://www.cms.hhs.gov/Transmittals/downloads/R1765CP.pdf** on the CMS Web site. The *2009 Jurisdiction List* is attached to CR 6522.

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

Addition/Deletion of HCPCS Codes - October 2009 Quarterly Update (MM6594) (GEN)

MLN Matters® Number: MM6594
Related CR Release Date: August 28, 2009
Related CR Transmittal #: R1805CP
Related Change Request (CR) #: 6594
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

Provider Types Affected
Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
This article explains updates, effective for dates of service on or after October 1, 2009 (unless otherwise specified), to the Healthcare Common Procedure Coding System (HCPCS) codes for certain drugs and biologicals. Ensure that your staffs are aware of these changes.

Background
The HCPCS code set is updated on a quarterly basis. This article describes updates for specific HCPCS codes and the October 2009 update has only one new code payable for Medicare. Effective for claims with dates of service on or after October 1, 2009, the following HCPCS code will be payable for Medicare:

- HCPCS Code Q2024 with short description of Bevacizumab injection and long description of INJECTION, BEVACIZUMAB, 0.25 MG, a Type of Service Code 1or P and a Medicare Physician Fee Schedule Data Base Status Indicator of E.

There are no deletions of HCPCS codes effective for October 1, 2009.

Additional Information
If you have questions, please contact your Medicare carrier, FI, DME MAC and/or MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site. The official instruction, CR6594, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding this change, may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1805CP.pdf** on the CMS Web site.

Additional Instructions on Processing Claims for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items Submitted Under the Guidelines Established in Change Request (CR) 5917 (MM6573) (GEN)

MLN Matters® Number: MM6573
Related CR Release Date: August 14, 2009
Related CR Transmittal #: R531OTN
Related Change Request (CR) #: 6573
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Provider Types Affected
Providers and suppliers billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6573 in order to augment previously issued CR 5917. In CR 5917 CMS instructed Medicare contractors to process and pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME when submitted by suppliers that are enrolled with both the National Supplier Clearinghouse (NSC) and with their local carrier/MAC. Although CR 5917 reinstated the local carrier/A/B MAC jurisdiction for claims for these items, the **instruction was not clear about the jurisdiction or payment rules to apply when the beneficiary resides outside of the local carrier/A/B Medicare Administrative Contractor's (A/B MAC) jurisdiction.** Be sure billing staff are aware of the changes.

Background
CR 6573 clarifies the claims filing jurisdiction and payment policies for claims submitted under the guidelines established in CR 5917 when the beneficiary is located outside of the local carrier/A/B Mac's jurisdiction. Payment of DMEPOS items is based on the fee schedule amount for the State where the beneficiary maintains their permanent residence.

CR 6573 also makes a correction to CR 5917 to replace the list of codes that may be billed, originally included as Attachment A to CR 5917, with the revised list of HCPCS codes attached to CR6573 and available at **http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf** on the CMS Web site. (In CR 5917 this list included codes for implanted devices, which may not be separately billed to the carrier/MAC by DMEPOS suppliers.)

Key Points of CR 6573

- Suppliers that are enrolled with the NSC as a DMEPOS supplier may enroll with and bill claims to their local carrier/A/B MAC for any of the attached list of DMEPOS items when billed under the guidelines established in CR 5917, including items furnished to beneficiaries who reside in other States.

- Medicare contractors will determine the claims filing jurisdiction for items billed under the guidelines established in CR 5917 based on the location of the supplier, in accordance with Chapter 1, section 10 of the *Medicare Claims Processing Manual* available at **http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf** on the CMS Web site.

- Medicare contractors will pay claims for items submitted under the guidelines established in CR 5917 by applying the appropriate fee schedule amount for the State where the beneficiary maintains his or her permanent residence.

- Under no circumstances may any entity enrolled as a DMEPOS supplier with the NSC, that is not the physician or provider that implants the device, bill the carrier/A/B MAC for an implanted device. However, DMEPOS suppliers may bill for any of the replacement parts, accessories or supplies for prosthetic implants and surgically implanted DME included in the attached revised list of HCPCS codes, under the guidelines established in CR 5917.

Additional Information

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

The official instruction (CR 6573) issued to your Medicare Carrier or A/B MAC is available at **http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf** on the CMS Web site. CR 6573 contains the **DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME** (*Rev. March 2009*) and that list is an attachment to CR 6573.

To review MM5917, the ***MLN Matters***® article related to CR 5917, go to **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5917.pdf** on the CMS Web site.

Billing for the Administration of the Influenza A (H1N1) Virus Vaccine (SE0920) (GEN)

MLN Matters® Number: SE0920
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

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

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

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

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

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

Additional Information

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

Claim Status Category Code and Claim Status Code Update (MM6609) (GEN)

MLN Matters® Number: MM6609
Related CR Release Date: August 14, 2009
Related CR Transmittal #: R1797CP
Related Change Request (CR) #: 6609
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

Provider Action Needed
This article, based on CR6609, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the June 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on the Internet on or about June 30, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background
The *Health Insurance Portability and Accountability Act* (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status.

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

The official instruction, CR6609, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1797CP.pdf** on the CMS Web site.

Compliance Standards for Consignment Closets and Stock and Bill Arrangements (MM6528) (GEN)

MLN Matters® Number: MM6528 - Revised
Related CR Release Date: September 1, 2009
Related CR Transmittal #: R300PI
Related Change Request (CR) #: 6528
Effective Date: September 8, 2009
Implementation Date: March 1, 2010

Note: *This article was revised on September 2, 2009, to reflect the revised CR 6528, issued by the Centers for Medicare & Medicaid Services on September 1, 2009. The CR release date, transmittal number, implementation date, and the Web address for accessing CR 6528 have been changed. All other information remains the same.*

Provider Types Affected
Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) which maintain inventory at a practice location owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution and which submit claims to the National Supplier Clearinghouse Medicare Administrative Contractor (NSC-MAC) are affected. In addition, physicians and non-physician practitioners who maintain DMEPOS inventory at the physician or non-physician practitioner's practice location for the purpose of DMEPOS distribution should be aware of this issue.

Provider Action Needed
DMEPOS suppliers, physicians and non-physician practitioners who maintain consignment closets and stock and bill arrangements for DMEPOS must comply with current standards, which may be verified by the NSC-MAC. Providers should assure that their billing staff are advised of these billing and compliance standards.

Background
This article is based on CR 6528, which defines and prohibits certain arrangements where an enrolled DMEPOS supplier maintains inventory at a practice location that is not owned by the enrolled DMEPOS supplier, but rather, owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution, commonly referred to as a consignment closet and/or stock and bill arrangement. A common practice example is that of an enrolled physician practice that allows DMEPOS owned by a separately enrolled DMEPOS supplier to be kept at the physician's practice location.

CR 6528 instructs the NSC-MAC that use of consignment closets and/or stock and bill arrangements, as defined in the background above, must be in compliance with current standards. In addition, the CR defines additional specific compliance standards for NSC-MAC validation for consignment closets and stock and bill arrangements added to the *Medicare Program Integrity Manual* (PIM), chapter 10, section 21.8, and viewable as an attachment to CR 6528 at **http://www.cms.hhs.gov/Transmittals/downloads/R300PI.pdf** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Medicare allows Medicare enrolled DMEPOS suppliers to maintain inventory at a practice location owned by a physician or non-physician practitioner for the purpose of DMEPOS distribution when the following conditions are met by the DMEPOS supplier and verified by the NSC-MAC:

- The title to the DMEPOS shall be transferred to the enrolled physician or non-physician practitioner's practice at the time the DMEPOS is furnished to the beneficiary.
- The physician or non-physician practitioner's practice shall bill for the DMEPOS supplies and services using their own enrolled DMEPOS billing number.
- All services provided to a Medicare beneficiary concerning fitting or use of the DMEPOS shall be performed by individuals being paid by the physician or non-physician practitioner's practice, not by any other DMEPOS supplier.
- The beneficiary shall be advised that, if they have a problem or questions with the DMEPOS, they should contact the physician or non-physician practitioner's practice, not the DMEPOS supplier who placed the DMEPOS at the physician or non-physician practitioner's practice.

The NSC-MAC shall verify that no more than one enrolled DMEPOS supplier shall be enrolled and/or located at the same practice location. (**Note:** *This prohibition does not exist for one or more physicians enrolled as DMEPOS suppliers at the same physical location.*) A practice location shall have a separate entrance and separate post office address, recognized by the United States Postal Service.

The NSC-MAC customer service personnel shall respond to direct provider and/or supplier questions concerning compliance with this policy. The responsibility for determining compliance with these provisions is the responsibility of the DMEPOS supplier, physician, or non-physician practitioner.

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

The official instruction, CR 6528, issued to the Medicare NSC-MAC regarding this change, may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R300PI.pdf** on the CMS Web site.

Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplier (DMEPOS) Suppliers Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs) (MM6421) (GEN)

MLN Matters Number: MM6421
Related CR Release Date: April 24, 2009
Related CR Transmittal #: R480OTN

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

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

Provider Action Needed
This article is based on change request (CR) 6421, which requires Medicare implementation of system edits to assure that DMEPOS suppliers bill for services **only** when ordered/referred by physician and non-physician practitioners who can order/refer such services. Physician and non-physician practitioners who order/refer services for Medicare beneficiaries must be enrolled in the Centers for Medicare & Medicaid Services' (CMS) Provider Enrollment, Chain and Ownership System (PECOS) and of a specialty that is eligible to order or refer. Be sure billing staff are aware of these changes that will impact claims received and processed on or after October 5, 2009.

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

The providers who can order/refer are:

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

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

Key Points

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

- **During Phase 2, (January 4, 2010 and thereafter):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in

PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS and not eligible to order and refer, the claim will not be paid.**

- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported on the claim against PECOS.
- When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.
- Providers who order or refer may want to verify their enrollment in PECOS. They may access the CMS PECOS site at **http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp** on the CMS Web site.

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

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R480OTN.pdf** on the CMS Web site.

Expiration of Medicare Processing of Certain Indian Health Service (IHS) Part B Claims - Sunset of Section 630 of the Medicare Modernization Act (MMA) of 2003 for Payment of Indian Health Services (IHS) (SE0912) (GEN)

MLN Matters® Number: SE0912
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: 3288
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
Indian Health Service (IHS), tribe and tribal organizations (non-hospital or non-hospital based) facilities submitting claims to Medicare contractors (carrier or DME Medicare Administrative Contractors (DME MACs)).

Provider Action Needed
This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected Indian Health Service (IHS) physicians, IHS providers, and IHS suppliers that beginning January 1, 2010, IHS facilities can no longer bill Medicare for 'other' Part B services, including Durable Medical Equipment (DME), prosthetics, orthotics, therapeutic shoes, clinical laboratory services, surgical dressing, splints and casts, drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier) and ambulance services. As a result of the *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA) of 2003, coverage of these 'other' Part B items and services started January 1, 2005 for a five-year period which ends January 1, 2010. This article alerts affected providers that the five-year period expires as of January 1, 2010.

Background
The *Social Security Act* (Section 1880; see **http://www.ssa.gov/OP_Home/ssact/title18/1880.htm** on the Internet) provides for payment to Indian Health Service (IHS) facilities for services paid under the physician fee schedule.

Additionally, the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA, Section 630) expanded the scope of items and services for which payment could be made to IHS facilities to include all 'other' Part B covered items and services for a 5 year period beginning January 1, 2005 and ending January 1, 2010. See Change Request (CR) 3288 at **http://www.cms.hhs.gov/transmittals/downloads/R241CP.PDF** on the Centers for Medicare & Medicaid Services (CMS) Web site. An ***MLN Matters***® article related to that transmittal is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3288.pdf** on the CMS Web site.

This special edition article is being provided by CMS to notify affected IHS physicians, IHS providers, and IHS suppliers that beginning January 1, 2010, IHS facilities can no longer bill Medicare for the following Part B services:

- Durable medical equipment (DME);
- Prosthetics and orthotics;
- Surgical dressings, Splints and Casts;
- Therapeutic shoes;
- Drugs (those processed by the DME/MACs and those processed by the A/B MACs and the Part B carrier);
- Clinical laboratory services; and
- Ambulance services.

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

July Quarterly Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM6511) (GEN)

MLN Matters® Number: MM6511
Related CR Release Date: June 5, 2009
Related CR Transmittal #: R1754CP
Related Change Request (CR) #: 6511
Effective Date: January 1, 2009 for implementation of fee schedule amounts for codes in effect then; April 1, 2009 for code K0739; July 1, 2009 for all other changes
Implementation Date: July 6, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6511 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

Background
The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is located in section 60, Chapter 23 of the *Medicare Claims Processing Manual* and is located at **http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf** on the CMS Web site. Other information on the fee schedule, including access to the DMEPOS fee schedules is at **http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp** on the CMS Web site.

Key Points of CR 6511

- The following table identifies the 2009 fees for the Healthcare Common Procedure Codes System (HCPCS) codes K0739/E1340. The * denotes revised for the 2009 fee schedule.

State	K0739/E1340	State	K0739/E1340
AK*	25.27	MT	13.41
AL*	13.41	NC	13.41
AR*	13.41	ND*	16.72
AZ*	16.59	NE	13.41
CA*	20.58	NH*	14.40
CO*	13.41	NJ*	18.10
CT*	22.40	NM*	13.41
DC*	13.41	NV*	21.37
DE*	24.71	NY*	24.71
FL*	13.41	OH*	13.41
GA*	13.41	OK	13.41
HI*	16.59	OR	13.41
IA*	13.41	PA*	14.40
ID*	13.41	PR	13.41
IL	13.41	RI*	15.99
IN	13.41	SC	13.41
KS	13.41	SD*	14.99
KY	13.41	TN	13.41
LA	13.41	TX	13.41
MA*	22.40	UT*	13.45
MD	13.41	VA	13.41
ME*	22.40	VI	13.41
MI	13.41	VT*	14.40
MN	13.41	WA*	21.37
MO	13.41	WI	13.41
MS	13.41	WV	13.41
		WY*	18.70

- The 2009 allowed payment amounts for codes E1340/K0739 are revised as part of this quarterly update to reflect updates that were brought to CMS' attention. The allowed payment amounts (listed above) for codes E1340/K0739 are effective as follows:

    - For claims with dates of service from January 1, 2009, through March 31, 2009 submitted using HCPCS code E1340 (Repair or Non-routine Service for DME Requiring the Skill of a Technician, Labor Component, Per 15 Minutes); and

  - For claims with dates of service from April 1, 2009, through December 31, 2009 submitted using code K0739 (Repair or Non-routine Service for DME Other Than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes).

- Medicare contractors will adjust previously processed claims for HCPCS code E1340/K0739 with dates of service on or after January 1, 2009 through June 30, 2009, if they are resubmitted as adjustments.

- HCPCS codes A6545, E0656, E0657 and L0113 were added to the HCPCS file effective January 1, 2009. The fee schedule amounts for these HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2009. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for the above codes with dates of service on or after January 1, 2009 that have already been processed will not be adjusted** to reflect the newly established fees if they are resubmitted for adjustment.

- As part of this update CMS is adding the AW modifier to the fee schedule file for HCPCS code A6545 *Gradient Compression Wrap, Non-Elastic, Below Knee, 30-50 MM HG, Each.* Code A6545 is covered when it is used in the treatment of an open venous stasis ulcer. Currently, code A6545 is noncovered for the following conditions:

  - Venous insufficiency without stasis ulcers, prevention of stasis ulcers, prevention of the reoccurrence of stasis ulcers that have healed, and treatment of lymphedema in the absence of ulcers. In these situations, since an ulcer is not present, the gradient compression wraps do not meet the definition of a surgical dressing. **Suppliers are advised that when the non-elastic gradient compression wrap code A6545 is used in the treatment of an open venous stasis ulcer, it must be billed with the AW modifier.** Claims for code A6545 that do not meet the covered indications should be billed without the AW modifier and as such, will be denied as non-covered.

- As part of this update, the fee schedule amounts for HCPCS code K0606 (Automatic External Defibrillator, with Integrated Electrocardiogram Analysis, Garment Type) billed without the KF modifier are being removed from the DMEPOS fee schedule file.

- A one-time notification regarding the changes in payment for oxygen and oxygen equipment as a result of the MIPPA of 2008 and additional instructions regarding payment for DMEPOS was issued on December 23, 2008, (Transmittal 421, Change Request (CR) 6297). A related ***MLN Matters*®** article may be reviewed at **http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6297.pdf** on the CMS Web site). CR 6297 included 2009 labor payment rates for HCPCS codes E1340, L4205 and L7520.

- In 2009, code K0739 was established in the HCPCS file to replace code E1340 for Medicare claims for the repair of beneficiary-owned DME with dates of service on or after April 1, 2009 (see Transmittal 443, CR 6296 issued on February 13, 2009 which may be reviewed at **http://www.cms.hhs.gov/transmittals/downloads/R443OTN.pdf** on the CMS Web site). The 2009 allowed payment amounts for code E1340 mapped directly to code K0739.

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 (CR6511) issued to your Medicare MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1754CP.pdf** on the CMS Web site.

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

New Drug/Biological Health Care Procedure Code System (HCPCS) Codes for July 2009 Update (MM6477) (DRU)

MLN Matters® Number: MM6477
Related CR Release Date: June 5, 2009
Related CR Transmittal #: R1752CP

Related Change Request (CR) #: 6477
Effective Date: July 1, 2009, except as noted in article
Implementation Date: July 6, 2009

Provider Types Affected
Physicians, hospitals, suppliers, and other providers who submit bills to Medicare carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for drugs and biologicals provided to Medicare beneficiaries.

Provider Action Needed
This article explains updates, effective for dates of service on or after July 1, 2009 (unless otherwise specified), to HCPCS codes for certain drugs and biologicals. Ensure that your staffs are aware of these changes.

Background
The HCPCS code set is updated on a quarterly basis. This article describes updates for specific drug/biological HCPCS codes. Effective for claims with dates of service on or after July 1, 2009, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	TOS Code	MPFSDB* Status Indicator
Q2023	Xyntha, inj	INJECTION, FACTOR VIII (ANTIHEMOPHILIC FACTOR, RECOMBINANT) (XYNTHA), PER I.U.	1	E
Q4115	Alloskin skin sub	SKIN SUBSTITUTE, ALLOSKIN, PER SQUARE CENTIMETER	1	E
Q4116	Alloderm skin sub	SKIN SUBSTITUTE, ALLODERM, PER SQUARE CENTIMETER	1	E

* MPFSDB - Medicare Physician Fee Schedule Data Base

The Medicare Coverage Indicator for the following codes was incorrectly listed on the January 2009, HCPCS code set file. With the July 2009 quarterly update to the HCPCS code set, we are correcting the file to show a Medicare Coverage Indicator of the letter "D". The letter "D" indicates that "special coverage instructions apply" and the applicable special coverage instructions are provided in the local coverage determinations (LCD) regarding inhalation drugs. These updates are based on change request (CR) 5981 and are effective for claims with dates of service on or after April 1, 2008. Note that Medicare contractors will not search for and adjust claims processed before this change is implemented. However, they will adjust such claims that you bring to their attention.

HCPCS Code	Short Description	Medicare Coverage Indicator
J7611	Albuterol non-comp con	D
J7612	Levalbuterol non-comp con	D
J7613	Albuterol non-comp unit	D
J7614	Levalbuterol non-comp unit	D

Additional Information
If you have questions, please contact your Medicare carrier, FI, DME MAC and/or MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site. The official instruction, CR 6477, issued to your Medicare carrier, FI, DME MAC and/or MAC regarding this change, may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1752CP.pdf** on the CMS Web site.

October 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6585) (DRU)

MLN Matters® Number: MM6585
Related CR Release Date: August 14, 2009
Related CR Transmittal #: R1795CP
Related Change Request (CR) #: 6585
Effective Date: October 1, 2009
Implementation Date: October 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.

Provider Action Needed
This article is based on Change Request (CR) 6585 and instructs Medicare contractors to download and implement the October 2009 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2009, April 2009, January 2009, and October 2008, files. Medicare will use the October 2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2009 with dates of service October 1, 2009, through December 31, 2009. See the Background and Additional Information Sections of this article for further details regarding these changes.

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

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 Outpatient Prospective Payment System (OPPS).

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

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

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the

medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

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

Files	Effective Dates of Service
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and ASP NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008

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 shall make these determinations.

Additional Information
The official instruction (CR6585) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1795CP.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.

CMS would like providers to be aware that the following ***MLN*** products are available through the ***MLN*** Catalogue:

1. The guide at **http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf** describes topics such as: types of Remittance Advice (RA), the purpose of the RA and types of codes that appear on the RA.

2. A fact sheet at **http://www.cms.hhs.gov/PQRI/Downloads/PQRIEPrescribingFactSheet.pdf** introduces the E-Prescribing Incentive Program as authorized by *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA).

3. The brochure at **http://www.cms.hhs.gov/MLNProducts/downloads/Protectingpracbroch508-09.pdf** highlights some the steps providers can employ to protect their practices from inappropriate Medicare business interactions.

October Quarterly Update to 2009 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement (MM6503) (GEN)

MLN Matters® Number: MM6503
Related CR Release Date: June 5, 2009
Related CR Transmittal #: R1750CP
Related Change Request (CR) #: 6503
Effective Date: January 1, 2009
Implementation Date: October 5, 2009

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

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

Provider Action Needed
This article is based on Change Request (CR) 6503 which provides the October quarterly update to the 2009 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) consolidated billing (CB). Be sure your billing staff know of the one change related to HCPCS L5670 as noted below.

Background
The *Social Security Act* (Section 1888; see **http://www.ssa.gov/OP_Home/ssact/title18/1888.htm** on the Internet) codifies Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law.

Services appearing on these lists of HCPCS will not be paid by Medicare to any providers other than a SNF **when included** in SNF CB. **Services excluded** from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

For October 1, 2009, the only change is that HCPCS code L5670 (Addition to lower extremity, below knee, molded supracondylar suspension ("PTS" or similar)) will be added to the File 1 Coding List for SNF CB for dates of service on or after January 1, 2009. Your Medicare DME MAC will re-open and re-process the claims you bring to their attention, that contain HCPCS L5670 with dates of service on or after January 1, 2009 and that have been previously denied prior to the implementation CR 6503.

Additional Information
The official instruction, CR 6503, issued to your DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1750CP.pdf** on the 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.

The Use of the CR Modifier and the DR Condition Code on Disaster/Emergency-Related Claims (MM6451) (GEN)

MLN Matters® Number: MM6451
Related CR Release Date: July 31, 2009
Related CR Transmittal #: R1784CP
Related Change Request (CR) #: 6451
Effective Date: August 31, 2009
Implementation Date: August 31, 2009

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

Provider Action Needed
This article is based on CR 6451, which updates and amends claims processing requirements for the use of condition codes and modifiers on Medicare fee-for-service claims when the furnishing of an item or service to a Medicare beneficiary was affected by a disaster or other general public emergency. CR 6451 also establishes a new chapter in the *Medicare Claims Processing Manual* dedicated to standing policies and procedures applicable to disasters and other public emergencies. Please make sure your billing staff is familiar with these changes, especially if they submit claims affected by emergencies to Medicare.

Background
As part of its response to the 2005 *Katrina* hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed the "DR" condition code and the "CR" modifier to facilitate the processing of claims affected by that emergency. The DR condition code and CR modifier were also authorized for use on claims for items and services affected by subsequent emergencies. Based on that

experience, the Medicare fee-for-service program is refining the uses of both the code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/suppliers in emergency situations without adding undue administrative burden associated with claim submission. The use of the "CR" modifier and "DR" condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.

Key Points of CR 6451

The DR Condition Code: The title of the DR condition code is "disaster related" and its definition requires it to be "used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster." The DR condition code is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. In previous emergencies, use of the DR condition code was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned directly or indirectly on the presence of a "formal waiver."

The CR Modifier: Both the short and long descriptors of the CR modifier are "catastrophe/disaster related." The CR modifier is used in relation to Part B items and services for both institutional and non-institutional billing. Non-institutional billing, i.e., claims submitted by "physicians and other suppliers", are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or - for pharmacies - in the NCPDP format. In previous emergencies, use of the CR modifier was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier's discretion. Effective August 31, 2009, use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned directly or indirectly on the presence of a "formal waiver."

Formal Waivers: A "formal waiver" is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers. One type is a waiver of a requirement specified in Section 1135(b) of the *Social Security Act* (Act). Although Medicare payment rules themselves are not "waivable" under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred. The second type of formal waiver is a waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the "3-day qualifying hospital stay" requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the *Social Security Act*.

Further Instructions in the Event of a Disaster or Emergency: In the event of a disaster or emergency, CMS will issue specific guidance to Medicare contractors that will contain a summary of the Secretary's declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.

Additional Information

The official instruction, CR 6451, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1784CP.pdf** on the CMS Web site.

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

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

DME MAC Jurisdiction A Correspondence - P.O. Box Reminder (GEN)

Please be sure to use the appropriate P.O. Boxes when sending correspondence to NHIC, Corp. DME MAC Jurisdiction A:

The following is a list of the appropriate P.O. Boxes to use:

P.O. Box 9146	General Written Inquiries
P.O. Box 9150	Redetermination requests
P.O. Box 9170	Reopening requests

P.O. boxes established for all other Medicare B covered services should not be used for DME inquiries.

Note: If for any reason you are addressing your items and are not using the P.O. Box, but the street address, please be sure to indicate **NHIC, Corp. DME MAC Jurisdiction A** on the envelope. Failure to indicate this could cause a delay in the receipt of your inquiry by the appropriate contractor.

Additional Contact Information can be found on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/contacts.shtml**

Fee Schedule Updates (GEN)

The 2009 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. This quarter the following notices have been posted:

- July Update to the 2009 Jurisdiction A DME MAC Fee Schedule
- July 2009 Quarterly Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2009 Oral Anticancer Drug Fees

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

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

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

Claim Status Category Code and Claim Status Code Update (MM6525) (GEN)

MLN Matters® Number: MM6525
Related CR Release Date: June 12, 2009
Related CR Transmittal #: R1756CP
Related Change Request (CR) #: 6525
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

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

Provider Action Needed
This article, based on CR6525, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on the Internet on March 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background
The *Health Insurance Portability and Accountability Act (HIPAA)* requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the January 2009 committee meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on March 1, 2009. Medicare will implement those changes on July 6, 2009 as a result of CR6525.

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

The official instruction issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1756CP.pdf** on the CMS Web site.

Healthcare Provider Taxonomy Codes (HPTC) October 2009 Update (CR6598) (GEN)

HIPAA requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The *X12 837 Professional Implementation Guide* used for Durable Medical Equipment (DME) claims requires the use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

The taxonomy code is not required for processing Medicare claims. However, if a taxonomy code is submitted, it must be valid according to the HPTC code set. The HPTC code set is named in the 837 professional implementation guide, thus CEDI must validate the inbound taxonomy codes against this HPTC maintained code source.

The HPTC list is available from the Washington Publishing Company (WPC). To view the October 2009 changes, visit the WPC Web site at: **http://www.wpc-edi.com/codes/taxonomy** , then select "New Codes" for a listing of new HPTCs or "Modifications" for a listing of modified HPTCs.

Please contact the CEDI Help Desk at 866-311-9184 or by e-mail at **ngs.cedihelpdesk@wellpoint.com** if you have questions.

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.

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (MM6520) (GEN)

MLN Matters® Number: MM6520
Related CR Release Date: July 10, 2009
Related CR Transmittal #: R1770CP
Related Change Request (CR) #: 6520
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

Provider Action Needed
This article is based on Change Request (CR) 6520 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Web site at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage** , or at the National Center for Health Statistics (NCHS) Web site at **http://www.cdc.gov/nchs/icd9.htm** in June of each year.

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

CMS issued CR 6520 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2009 (for institutional providers, effective for discharges on or after October 1, 2009).

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

Additional Information
If you have questions, please contact your Medicare MAC and/or FI/carrier 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 (CR6520) issued to your Medicare MAC and/or FI/carrier is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1770CP.pdf** on the CMS Web site.

Medicare Parts A and B Coverage and Prior Authorization (SE0916) (GEN)

MLN Matters® Number: SE0916 - 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 August 28, 2009, to provide additional information regarding NCDs and LCDs.*

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

Provider Action Needed
This article is based on the *Social Security Act* and other laws which describe covered and non-covered items and services and their payment under Part A and Part B. Originally, the *Social Security Act* did not authorize any form of "prior authorization" for Medicare services. The law was subsequently changed to allow prior authorization of limited items of Durable Medical Equipment and physicians' services. Currently, Medicare does not pre-authorize coverage of any item or service that will receive payment under Part A or B, **except for custom wheelchairs**. *Please advise all staff and inform your Medicare patients, as appropriate, that Medicare does not currently pre-authorize coverage for any item or service other than custom wheelchairs.*

Background
The overall scope of allowable benefits under the Medicare program is prescribed by law. When Medicare was established, Congress included certain provisions on the broad categories of items and services that may be covered under the Medicare program as well as provisions on certain items and services that were to be excluded from coverage. Congress also included in Section 1862(a)(1)(A) of the *Social Security Act* the following provision:

> "*Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which…are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,...*"

This clause has become known as the "reasonable and necessary" provision. Medicare coverage and payment for items and services is therefore contingent upon a determination that an item and service:

- Falls within a benefit category;
- Is not specifically excluded from coverage; and
- The item or service is "reasonable and necessary" unless specifically excluded from meeting this provision.

Also, as prescribed by law, the Centers for Medicare & Medicaid Services (CMS) develops National Coverage Determinations (NCDs), which are national policy statements granting, limiting, or excluding Medicare coverage for a particular item or service. NCDs may be found in the *Medicare National Coverage Determinations Manual* (Publication #100-03) at **http://www.cms.hhs.gov/Manuals/IOM/list.asp** on the CMS Web site.

For those items or services whose coverage is not determined in law, regulation or NCD, the local Medicare contractors are authorized to develop local coverage determinations (LCDs) to further determine coverage of items and services covered by Medicare. LCDs specify under what conditions an item or service is considered to be "reasonable and necessary". Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, including comments from the provider community. LCDs may be found on the CMS coverage Web site and your local contractor's Web site.

If a provider believes that a Medicare NCD or LCD needs to be revised, they should request CMS or its contractors to reconsider the existing NCD or LCD. What factors CMS considers when deciding to open or reopen an NCD can be found at **https://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=6** on the CMS Web site. To request a new LCD or an LCD reconsideration, the provider should contact the local Medicare contractor.

In regard to prior authorization under fee-for-service Medicare, providers should be aware that section 1834(a)(15)(c) of the *Social Security Act* allows for an Advance Determination of Medicare Coverage (ADMC) for certain items of Durable Medical Equipment (DME). The only items of DME currently subject to this provision are custom wheelchairs. Also, Section 938 of the *Medicare Prescription Drug Improvement and Modernization Act of 2003* (Public Law 108-173) required the Secretary to establish a "Prior Determination" process for a limited number of physicians' services under Medicare. Implementation of this provision is pending. It should also be noted that Medicare Part C & Part D programs are authorized to have and may require prior authorizations for services billed to them.

Additional Information
The *Social Security Act* Amendments of 1965, Section 1862 (a)(1)(A) can be viewed at **http://www.ssa.gov/OP_Home/ssact/title18/1862.htm** on the Social Security Web site.

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

Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program Round One Rebid in calendar year (CY) 2009 (MM6571) (GEN)

MLN Matters® Number: MM6571
Related CR Release Date: August 3, 2009
Related CR Transmittal #: R527OTN

Related Change Request (CR) #: 6571
Effective Date: August 3, 2009
Implementation Date: September 3, 2009

Provider Types Affected
Medicare DMEPOS suppliers that bill DME Medicare Administrative Contractors (DME MACs) as well as providers that bill Medicare Regional Home Health Intermediaries (RHHIs) or Part A/B Medicare Administrative Contractors (A/B MACs) whom refer or order DMEPOS for Medicare beneficiaries.

What You Need To Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6571 in order to identify the nine metropolitan statistical areas (MSAs) as well as product categories in which the DMEPOS competitive bidding round one re-bid will occur in CY 2009 under section 1847 of the *Social Security Act*.

Key Points of CR6571
As mandated by the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), the DMEPOS Competitive Bidding Round One rebid in 2009 will occur in the following 9 MSAs:

- Cincinnati - Middletown (Ohio, Kentucky and Indiana);
- Cleveland - Elyria - Mentor (Ohio);
- Charlotte - Gastonia - Concord (North Carolina and South Carolina);
- Dallas - Fort Worth - Arlington (Texas);
- Kansas City (Missouri and Kansas);
- Miami - Fort Lauderdale - Miami Beach (Florida);
- Orlando (Florida);
- Pittsburgh (Pennsylvania); and
- Riverside - San Bernardino - Ontario (California)

Further information on the boundaries and list of zip codes for each competitive bid area (CBA) and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp** on the CMS Web site and following the link to Competitive Bidding Implementation Contractor (CBIC).

The DMEPOS Competitive Bidding Round One rebid in 2009 will include the following 9 product categories:

- Oxygen Supplies and Equipment;
- Standard Power Wheelchairs, Scooters, and Related Accessories;
- Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2);
- Mail-Order Diabetic Supplies;
- Enteral Nutrients, Equipment and Supplies;
- Continuous Positive Airway Pressure (CPAP), Respiratory Assist Devices (RADs), and Related Supplies and Accessories;
- Hospital Beds and Related Accessories;
- Walkers and Related Accessories; and
- Support Surfaces (Group 2 mattresses and overlays) in Miami

The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round I rebid in 2009 can also be found at **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/01_overview.asp** on the CMS Web site.

Suppliers and providers may call the Provider Contact Centers with competitive bidding inquiries at the CBIC Competitive Bidding Program Helpdesk at 1-877-577-5331 or go to the "Contact Us" feature on the CBIC Competitive Bidding Program Web site at **http://www.dmecompetitivebid.com/** on the Internet to submit competitive bidding specific questions.

Background
The Medicare payment for most DMEPOS is currently based on fee schedules. However, section 302(b) of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA), which amended section 1847 of the *Social Security Act* (the Act), mandates a competitive bidding program to replace the current DMEPOS fee schedule payment amounts for selected items in selected areas.

The statute provides that competitive bidding will apply to DME meeting the definition of a "covered item" as specified in section 1834(a) (13) of the Act, including items used in infusion and drugs (other than inhalation drugs) and supplies used in conjunction with DME, but excluding class III devices under the *Federal Food, Drug and Cosmetic Act*. Competitive bidding will also apply to enteral nutrients, equipment, and supplies. Further, competitive bidding will apply to off-the-shelf orthotics described in section 1861(s)(9) for which payment would otherwise be made under Section 1834(h) which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual.

The statute, as amended by the MMA, also provided for phasing in competitive bidding beginning in 10 of the largest MSAs. Areas that may be exempt from the DMEPOS competitive bidding program include rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service.

Round One of the DMEPOS competitive bidding program was implemented on July 1, 2008, in ten competitive bidding areas, as mandated by the MMA. However, as part of MIPPA, Congress enacted a temporary delay in the competitive bidding program for Round One Competitive Bidding Areas. The law required CMS to terminate the existing contracts that were awarded in Round One and conduct a second Round One competition (the "Round One rebid") in 2009. The MIPPA also excluded certain Round One DMEPOS items and areas from the competitive bidding program. Section 154(a) of the MIPPA exempted group three complex rehabilitative power wheelchairs and related accessories when furnished in connection with such wheelchairs for the Round One rebid and subsequent rounds of the program, as well as, negative pressure wound therapy (NPWT) items and services from the Round One rebid competition. The MIPPA also excluded Puerto Rico as an area so that the Round One rebid competition covers nine, instead of ten of the largest MSAs. Except for the aforementioned exceptions, section 154(a) of the MIPPA requires that the Round One rebid occur in 2009 with the same items and services and the same areas as in Round One.

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

The official instruction (CR6571) issued to your Medicare DME/MAC, RHHI or A/B MAC is available at **http://www.cms.hhs.gov/Transmittals/downloads/R527OTN.pdf** on the CMS Web site.

For clarification of the initial delay in the DMEPOS competitive bidding program you may review MM6203 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6203.pdf** on the CMS Web site.

Review of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM6468) (GEN)

MLN Matters® Number: MM6468
Related CR Release Date: June 12, 2009
Related CR Transmittal #: R293PI
Related Change Request (CR) #: 6468
Effective Date: June 1, 2009
Implementation Date: July 13, 2009

This article was rescinded on July 2, 2009, because related CR 6468 was rescinded on that date.

Take Action Now to Prepare for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (SE0915) (GEN)

MLN Matters® Number: SE0915
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
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that wish to participate in the upcoming Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program.

Provider Action Needed
In order to participate in the 2009 Round 1 Rebid of the DMEPOS Competitive Bidding Program, suppliers will be required to register in the Centers for Medicare & Medicaid Services (CMS) security system known as the Individuals Authorized Access to the CMS Computer Services (IACS). This includes suppliers that bid in the first round of competition in 2007 and are interested in competing in the Round 1 Rebid. CMS urges suppliers' planning to bid in the 2009 bidding cycle to be sure that they have provided the National Supplier Clearinghouse (NSC) an updated CMS-855S (Medicare Enrollment Application), with any changes made concerning their Authorized Official(s) information and correspondence mailing address which have occurred since their last CMS-855S submission. The accuracy of this data is critical for successful bidder registration.

Background
In this year's bid cycle, suppliers who wish to bid will need to first register in IACS once the registration window opens. There will be three user roles available, which are described as follows:

- Authorized Official (AO) - Each supplier's organization will be allowed one AO. The AO role can approve all other users associated with their organization who are requesting access to the bidding system. The AO will be able to input bid data, approve Form A and certify Form B in the bidding system.

- Backup Authorized Official (BAO) - Each supplier organization is encouraged to designate one or more BAOs. This applies when the organization has additional personnel who qualify as an AO. In this role, the BAO can approve the supplier's End User registration for access to the bidding system. Like the AO, the BAO can also input bid data, approve Form A and certify Form B in the bidding system.

- End User - Each supplier organization will be allowed one or more End User(s). The End User can input bid data, but cannot approve Form A or certify Form B.

Save Time and Potential Delay by Verifying CMS-855S Information Prior to Registering to Bid
Only those AOs listed on the CMS-855S as an AO can register in IACS to approve and certify as described above for the AO and BAO user roles. As part of the CMS-855S, a supplier designates one or more AO(s). The AO means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations and program instructions of the Medicare program.

Take Action Now
Be sure the most recent CMS-855S submission is current and accurate. In particular, this concerns:

- The AO's personal identifying information, including the AO's legal name, date of birth, and Social Security number (SSN) as on file with the Social Security Administration (SSA). Make sure the AO's legal name, date of birth and SSN in sections 6 and 15 of the CMS-855S reflects that which is on file with SSA. Reviewing a Social Security card or most recent Social Security Statement is a fast and easy way to verify information on file with SSA. If the information on file at SSA is not correct, then you should immediately contact SSA and have the correction made.

- The supplier's correspondence mailing address as reflected in section 2A2 of the CMS-855S.

If any of these data elements have changed since your last submission of the CMS-855S to the NSC or if the AO's personal identifying information on the CMS-855S does not exactly reflect that which is on file with the SSA, then you should PROMPTLY complete a

change of information on the CMS-855S. Remember, any change of name reported to SSA should also be reported to the NSC on the CMS-855S.

CMS urges suppliers to do it now. The NSC processing time to complete a change of information on the CMS-855S is approximately 45 days, and all submissions are processed in the order in which they are received.

Overview of IACS Registration Process
For an AO, the verification of his/her legal name, date of birth, and SSN must be validated against SSA's records and AO data maintained by the NSC. The NSC received this AO data when the supplier completed its most recent CMS-855S. The AO's legal name, date of birth, and SSN are listed in sections 6 and 15 of the CMS-855S. If the AO legal name, date of birth and SSN data input into IACS during registration does not match SSA's records and NSC AO data, the registration will be rejected.

Following successful registration, as an added measure of security, the AO's User ID and password are then mailed in two separate correspondences to the mailing address listed in section 2A2 of the CMS-855S.

The BAO goes through the same verification process described above for the AO and the AO for the organization must approve a BAO's request for access before a User ID and password will be e-mailed to the BAO. The BAO must be listed on the CMS-855S as an AO, sections 6 and 15. It is critical that the BAO's legal name, date of birth and SSN data input into IACS during registration matches SSA's records and NSC AO data, otherwise the BAO registration will be rejected.

End Users do not need to be listed on the CMS-855S as an AO. However, their legal name, date of birth and SSN will be verified against SSA's records, and the AO or BAO for the organization will need to approve an End User's request for access to the bidding system.

Do I need a BAO role?
The establishment of a BAO is encouraged, if the organization has someone that can occupy the BAO role, to avoid any disruption in the bidding process. The AO's role is instrumental to bidding, as the AO's role must be active to avoid all other users of the organization from losing access to the bidding system. If the AO leaves the organization, the BAO role can be changed to an AO role by the Competitive Bidding Implementation Contractor (CBIC) Help Desk.

Additional Information
This article provides you with an overview of the registration process. More detailed instructions will be published in future ***MLN Matters***® articles, listserv messages, and other announcements.

For more information on the DMEPOS competitive bidding program, visit **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS Web site.

CMS News Flash (GEN)

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

The *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), enacted on July 15, 2008, made limited changes to the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, including a requirement that competition to re-bid Round 1 occur in 2009. On January 16, 2009, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period that incorporates into regulations only those provisions of MIPPA related to the DMEPOS competitive bidding program that are self-implementing and necessary to conduct the Round 1 rebid competition in 2009. That rule became effective on April 18, 2009 and is available at **http://edocket.access.gpo.gov/2009/pdf/E9-863.pdf** on the Internet. It is crucial that DME suppliers be accredited in order to submit bids for the competitive bidding program. Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals/persons exempted from

accreditation may be found at **http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationOrganizations.asp** on the CMS Web site.

The *General Equivalence Mappings - ICD-9-CM To and From ICD-10-CM and ICD-10-PCS Fact Sheet* (March 2009), which provides information and resources regarding the General Equivalence Mappings that were developed as a tool to assist with the conversion of *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM)* codes to *International Classification of Diseases, 10th Edition (ICD-10)* and the conversion of ICD-10 codes back to ICD-9-CM, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) ***Medicare Learning Network*** at **http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10_GEM_factsheet.pdf** on the CMS Web site. The fact sheet is also available in print format. To place your order, visit **http://www.cms.hhs.gov/MLNGenInfo/** , scroll down to "Related Links Inside CMS" and select "***MLN*** Product Ordering Page."

The Centers for Medicare & Medicaid Services (CMS) has announced **the next steps for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program**. Suppliers interested in bidding should prepare now! Suppliers must ensure the information listed on their enrollment files at the National Supplier Clearinghouse (NSC) is accurate to enable participation in this program. Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all state licensure requirements for DMEPOS and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Prior to submitting a bid for a CBA and product category, the supplier must have a copy of the applicable state licenses on file with the NSC. Suppliers must be accredited for a product category to submit a bid for that product category. Suppliers subject to the surety bond requirement must be bonded in order to bid. For more information on the Medicare DMEPOS Competitive Bidding Program please visit **http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/** on the CMS Web site.

The Second in Series: *General Equivalence Mappings - ICD-9-CM to and from ICD-10-CM and ICD-10-PCS Fact Sheet* (May 2009), which provides basic information about the General Equivalence Mappings (GEM) including possible users of the GEMs, why the GEMs are needed, and how the GEMs files are formatted as well as Reimbursement Mappings information, is now available in downloadable format from the Centers for Medicare & Medicaid Services ***Medicare Learning Network*** at **http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfctsht.pdf** on the CMS Web site.

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

An *ICD-10-CM-PCS Bookmark* (revised August 2009), which provides information about the ICD-10-Clinical Modification/Procedure Coding System including the benefits of adopting the coding system, recommended steps to be taken in order to plan and prepare for implementation of the coding system, and where additional information about the coding system can be found, is now available in downloadable format at **http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10ClinModBookmrk.pdf** on the CMS Web site.

The publication titled *ICD-10-CM/PCS Myths & Facts* (June 2009), which presents correct information in response to some myths regarding the ICD-10-Clinical Modification/Procedure Coding System, is now available in downloadable format from the Centers for Medicare & Medicaid Services ***Medicare Learning Network*** at **http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10Mappingfctsht.pdf** on the CMS Web site.

On June 9, 2009, the Centers for Medicare & Medicaid Services (CMS) conducted a national provider conference call on the HIPAA Versions 5010 and D.0. You can view the presentation, transcript and listen to the audio file from that call by accessing **http://www.cms.hhs.gov/Versions5010andD0/Downloads/6-9-2009_National_Provider_Call.pdf** on the CMS Web site.

DME MAC Jurisdiction A Local Coverage Determinations (LCD)

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

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

LCD and Policy Article Revisions - Summary for June 25, 2009 (GEN)

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

Automatic External Defibrillators
LCD
Revision Effective Date: 09/01/2009
HCPCS MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers.

Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Canes and Crutches
Policy Article
Revision Effective Date: 07/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Cervical Traction Devices
LCD
Revision Effective Date: 09/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: E0856 from range of covered codes.
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers.

Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Cold Therapy
Policy Article
Revision Effective Date: 07/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Commodes
LCD
Revision Effective Date: 09/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:
Removed: Reference to DMERC.
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA, GY and GZ modifiers.

Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Enteral Nutrition
Policy Article
Revision Effective Date: 07/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Instructions for delivery of supplies.
Changed: DMERC to DME MAC.
CODING GUIDELINES:
Clarified: Definition for supply kit codes B4034-B4036.
Changed: SADMERC to PDAC.

Epoetin
LCD
Revision Effective Date: 09/01/2009
CMS NATIONAL COVERAGE POLICY:
Added: CMS Pub. 100-2, *Medicare Benefit Policy Manual*, Chapter 15, Section 50.5.2.
HCPCS CODES AND MODIFIERS:
Added: GY modifier.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GY modifier.

Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Eye Prostheses
Policy Article
Revision Effective Date: 07/01/2009
CODING GUIDELINES:
Revised: RT/LT instructions.
Changed: SADMERC to PDAC.

Facial Prostheses
Policy Article
Revision Effective Date: 07/01/2009
CODING GUIDELINES:
Revised: RT/LT modifier instructions.
Changed: SADMERC to PDAC.

Home Dialysis Supplies and Equipment
LCD
Revision Effective Date: 09/01/2009
HCPCS CODES AND MODIFIERS:
Added: GY modifier.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GY modifier.

Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea
LCD
Revision Effective Date: 09/01/2009
HCPCS CODES AND MODIFIERS
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION:
Added: Information about the required use of GA, GZ or KX on claim lines for PAP devices and/or accessories.

Respiratory Assist Devices (RAD)
LCD
Revision Effective Date: 09/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers.

Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

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

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

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

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 01/01/2009 (June Revision)

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Clarified: Conditions for blood gas studies.
- Clarified: Testing requirements when exercise test results are used to qualify.
- Revised: Certification section to address new payment policy.
- Moved: Information on payment of greater than 4 LPM oxygen to the Policy Article, Non-Medical Necessity Coverage and Payment Rules section.

HCPCS CODES AND MODIFIERS:

- Added: RA modifier.

DOCUMENTATION REQUIREMENTS:

- Moved: CMN instructions to Indications and Limitations of Coverage section.
- Added: Instructions for replacement equipment.

Policy Article

Revision Effective Date: 01/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Updated: Entire section to account for new oxygen payment policy.

CODING GUIDELINES:

- Revised: Billing instructions for oxygen contents.
- Changed: SADMERC reference to PDAC.

BILLING INFORMATION:

- Created: New section for billing instructions.
- Added: Instructions on billing for oxygen contents.
- Moved: Statement about not separately payable items to this section.

Therapeutic Shoes for Persons with Diabetes

LCD

Revision Effective Date: 08/01/2009

CMS NATIONAL COVERAGE POLICY:

- Added: *Benefit Policy Manual* reference.

HCPCS CODES AND MODIFIERS:

- Added: GY modifier.

DOCUMENTATION REQUIREMENTS:

- Revised: Instructions for certification statement to indicate that it must be completed by the certifying physician.
- Revised: Instructions concerning KX modifier to refer to the Policy Article.
- Clarified: Information documenting that KX modifier requirements have been met must be in the records of the certifying physician.
- Added: Instructions for use of GY modifier.

Policy Article

Revision Effective Date: 08/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Clarified: Documentation of qualifying conditions must be in the medical records of the certifying physician. (This requirement has always been included in the national policy. The 08/01/2009 effective date does not apply.)

CODING GUIDELINES:

Clarified: Definitions of A5512 and A5513.

Revised: Billing instructions for the RT and LT modifiers.

Added: Statement that custom fabricated inserts do not require PDAC Coding Verification Review.

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

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

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

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 10/01/2009

INDICATIONS AND LIMITATIONS OF COVERAGE:

Clarified: Coverage criterion #2.

HCPCS CODES AND MODIFIERS:

Added: GA, GZ modifiers.

Revised: KX modifier.

DOCUMENTATION REQUIREMENTS:

Added: Instructions for GA and GZ modifiers.

Hospital Beds and Accessories

LCD

Revision Effective Date: 10/01/2009

HCPCS CODES AND MODIFIERS:

Revised: KX modifier.

DOCUMENTATION REQUIREMENTS:

Added: Instructions for the use of GA and GZ modifiers.

Policy Article

Revision Effective Date: 10/01/2009

CODING GUIDELINES:

Changed: SADMERC to PDAC.

Infrared Heating Pad Systems

Policy Article

Revision Effective Date: 08/01/2009

CODING GUIDELINES:

Changed: SADMERC to PDAC.

Intrapulmonary Percussive Ventilation Systems
Policy Article
Revision Effective Date: 08/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Manual Wheelchair Bases
LCD
Revision Effective Date: 10/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers.

Policy Article
Revision Effective Date: 10/01/2009
CODING GUIDELINES:
Deleted: E1161 from range of codes E1070-E1200.
Changed: SADMERC to PDAC.

Mechanical In-exsufflation Devices
Policy Article
Revision Effective Date: 08/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Negative Pressure Wound Therapy
LCD
Revision Effective Date: 10/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: *Program Integrity Manual* instructions on refills of supplies.
Changed: SADMERC to PDAC.
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers.
APPENDICES:
Revised: Pressure ulcer staging based on NPUAP guidelines.
SOURCES OF INFORMATION AND BASIS FOR DECISION:
Added: Reference to NPUAP guidelines for pressure ulcer staging.

Policy Article
Revision Effective Date: 10/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Orthopedic Footwear
LCD
Revision Effective Date: 10/01/2009
HCPCS CODES AND MODIFIERS:
Added: GY modifier.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: GY modifier instructions.

Policy Article
Revision Effective Date: 10/01/2009
CODING GUIDELINES:
Revised: RT/LT modifier instructions.
Changed: SADMERC to PDAC.

Osteogenesis Stimulators
LCD
Revision Effective Date: 08/01/2009
DOCUMENTATION REQUIREMENTS:
Included: Ultrasonic in statement regarding correct CMN to use for electrical osteogenesis stimulators.

Policy Article
Revision Effective Date: 08/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Parenteral Nutrition
LCD
Revision Effective Date: 10/01/2009
DOCUMENTATION REQUIREMENTS:
Revised: Instructions for submitting a revised DIF.

Policy Article
Revision Effective Date: 10/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: DMERC to DME MAC.
CODING GUIDELINES:
Revised: SADMERC to PDAC.

Power Mobility Devices
LCD
Revision Effective Date: 10/01/2009
HCPCS MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Revised: Requirements for detailed product description.
Added: Instructions for use of the GA and GZ modifiers.

Refractive Lenses
LCD
Revision Effective Date: 10/01/2009
HCPCS MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers.

Policy Article
Revision Effective Date: 10/01/2009
CODING GUIDELINES:
Revised: RT/LT modifier instructions.
Changed: SADMERC to PDAC.

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

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

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

Pressure Reducing Support Surfaces - Group 1
LCD
Revision Effective Date: 12/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Criteria for coverage of Group I Mattress.
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of GA and GZ modifiers.
APPENDICES:
Revised: Definitions of pressure ulcer stages.
SOURCES OF INFORMATION AND BASIS FOR DECISION:
Added: Reference to NPUAP guidelines for pressure ulcer staging.

Policy Article
Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC

Seat Lift Mechanisms
Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC

Speech Generating Devices
LCD
Revision Effective Date: 12/01/2009
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Multicomponent instructions.
Added: Instructions for the use of GA and GZ modifiers.

Policy Article
Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Revised: Instructions for mounting systems.
Changed: SADMERC to PDAC.

Suction Pumps
Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Surgical Dressings
Policy Article
Revision Effective Date: 01/01/2009 (September Publication)
CODING GUIDELINES:
Added: A6545 to list of codes requiring the AW modifier.
Added: A6545 to list of codes requiring the RT and/or LT modifier(s).
Revised: RT/LT modifier instructions.

Therapeutic Shoes for Persons with Diabetes
Policy Article
Revision Effective Date: 09/01/2009
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Clarified: Documentation of qualifying conditions must be in the medical records of the certifying physician. (This requirement has always been included in the national policy. 09/1/09 effective date does not apply.)
CODING GUIDELINES:
Revised: Billing instructions for the RT and LT modifiers.
Revised: Statement concerning which products billed with code A5513 must have PDAC Coding Verification Review.

Tracheostomy Care Supplies
Policy Article
Revision Effective Date: 09/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Transcutaneous Electrical Nerve Stimulators (TENS)
LCD

Revision Effective Date: 12/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Additional supply quantities denial statement.
HCPCS CODES AND MODIFIERS:
Added: GA and GZ modifiers.
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Removed: Instructions for additional quantities.
Added: Instructions for the use of GA and GZ modifiers.

Policy Article

Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC

Urological Supplies
LCD

Revision Effective Date: 12/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Additional quantity denial statements for tape, anchoring devices and leg-bag straps.
HCPCS CODES and MODIFIERS:
Revised: KX modifier.
DOCUMENTATION REQUIREMENTS:
Added: Instructions for the use of the GY modifier.
Removed: Instructions for additional quantities.

Policy Article

Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Clarified: A4353
Changed: SADMERC to PDAC.

Walkers
LCD

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

Policy Article

Revision Effective Date: 12/01/2009
CODING GUIDELINES:
Changed: SADMERC to PDAC.

Wheelchair Seating
LCD

Revision Effective Date: 12/01/2009
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Hemiplegia, Huntington's chorea, idiopathic torsion dystonia, and cerebral palsy to the list of covered conditions for skin protection seat cushions.
Added: Above knee amputations, osteogenesis imperfecta, and transverse myelitis to the list of covered conditions for positioning seat and back cushions and positioning accessories.
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: Corresponding ICD-9 codes.
HCPCS MODIFIERS:
Added: GA, GZ
DOCUMENTATION REQUIREMENTS:
Added: Instructions for use of GA and GZ modifiers.

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

Billing Reminder - Reopening Rejected Claims for Missing KX Modifiers (GEN)

Requesting a reopening to correct a claim that is missing one of these modifiers will no longer be an available option.

Effective for dates of service beginning August 1, 2009, the LCD for *Therapeutic Shoes for Persons with Diabetes* has revised instructions concerning the use of the KX and GY modifiers.

Recently use of the GA, GY and GZ modifiers has been added to some policies to indicate that the relevant KX modifier requirements have not been met. Failure to use these modifiers correctly will result in a rejection.

These changes will be effective for dates of service beginning September 1, 2009 for the following LCDs:

- Automatic External Defibrillators
- Cervical Traction Devices
- Commodes
- Epoetin
- Home Dialysis Supplies and Equipment
- Positive Airway Pressure Devices
- Respiratory Assist Devices

These changes will be effective for dates of service beginning October 1, 2009 for the following LCDs:

- High Frequency Chest Wall Oscillating (HFCWO) Devices
- Hospital Beds and Accessories
- Manual Wheelchair Bases
- Negative Pressure Wound Therapy (NPWT)
- Orthopedic Footwear
- Power Mobility Devices
- Refractive Lenses

Other policies will add these modifiers over the coming months.

Most claims denials occur as a result of a few common reasons. One of the most common is failure to add the KX modifier to a HCPCS code indicating that requirements specified in the medical policy have been met. In the past, these denials were often corrected either with a reopening or a redetermination request.

Rejected claims must be corrected and resubmitted. Neither the reopening nor redetermination process is able to address rejected claims.

Refer to each LCD for specific guidance on the use of these modifiers.

Charcot Restraint Orthotic Walker - CROW Boot - Coding (O&P)

The Charcot Restraint Orthotic Walker, also referred to as CROW boot or walker, was developed for patients with severe deformity of the foot and ankle due to a sensory neuropathic arthropathy - most commonly caused by diabetes. The device is a bi-valved copolymer full foot enclosure, totally encapsulated around the ankle and foot with a rocker bottom sole built into the device. The orthosis is custom fabricated to a positive model made from an impression of the patient's affected limb. It is fully lined and uses a custom foot insert. Appropriate modifications are performed to the impression, which permits for equal weight distribution through the limb and provides support of the ankle joint, tibia, and fibula. The CROW boot can be modified to accommodate changes by flaring, adding padding, and trimming where and when appropriate.

A CROW boot is billed using the following codes:

L1960 ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM-FABRICATED

L2232 ADDITION TO LOWER EXTREMITY ORTHOSIS, ROCKER BOTTOM FOR TOTAL CONTACT ANKLE FOOTORTHOSIS, FOR CUSTOM FABRICATED ORTHOSIS ONLY

L2275 ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION, PLASTIC MODIFICATION, PADDED/LINED

L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL

L2820 ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION

L3010 FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH

No other codes may be billed for a CROW boot. There is no separate billing for any modifications, fitting, or adjustments.

When these products are used solely to treat edema or ulcers or to prevent an ulcer of the lower extremity, suppliers should code them based on the patient's condition. HCPCS code A9283 (Foot pressure off loading / supportive device, any type, each) was developed to describe various devices used for the treatment of edema or for a lower extremity ulcer or for the prevention of ulcers. If the CROW boot is used for these conditions and the patient does not have Charcot arthropathy, then it should be coded A9283.

Suppliers should contact the Pricing, Data Analysis, and Coding contractor (PDAC) for guidance on the correct coding of specific items.

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

E2399 - Power Wheelchair - Not Otherwise Classified Interface (MOB)

Code E2399 describes an interface for a power wheelchair drive control system that is not described by any other HCPCS code. At the time of initial issue of a power wheelchair, this code would only be used for very uncommon types of drive control mechanisms - e.g., a fiber optic switch array.

The DME MAC receives a number of claims in which code E2399 is used for various joystick "upgrades", including but not limited to the Pride Mobility Products Q-Logic Drive Control System or the Permobil R-net Remote Joystick. This is incorrect coding. Code E2399 (or K0108 - wheelchair component or accessory, not otherwise specified) must never be used for a component or feature of a joystick at the time of initial issue of a wheelchair.

Reimbursement for a standard proportional remote joystick with a non-expandable controller is included in the allowance for a power wheelchair base. When a joystick with an expandable controller is provided at the time of initial issue, the following two codes are billed:

E2313 Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors, and mounting hardware, each

E2377 Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue

The reimbursement for these two codes includes payment for any additional "upgrade" component or feature of a proportional or nonproportional joystick. Although separate billing is discouraged, if a supplier elects to bill separately, code A9900 (Miscellaneous DME supply, accessory, and/or service component of another HCPCS code) must be used.

Claim lines for E2399 billed at the time of initial issue of a power wheelchair for an "upgrade" of a joystick or other drive control interface will be denied as not separately payable if they are billed with E2313 and/or E2377. If E2313 and E2377 are not billed, code E2399 will be rejected as incorrect billing.

Refer to the *Wheelchair Options and Accessories* Policy Article for definitions of expandable and non-expandable controllers and various types of drive control interfaces. The Policy Article also contains guidance concerning the use of code E2399 for replacement components.

Suppliers should contact the Pricing, Data Analysis, and Coding contractor (PDAC) for questions concerning the correct coding of specific products.

HCPCS Code A9283 - DEVICES USED FOR EDEMA OR ULCER HEALING (O&P)

HCPCS code A9283 (Foot pressure off loading / supportive device, any type, each) was developed to describe various devices used for the treatment of edema or for a lower extremity ulcer or for the prevention of ulcers.

When products are used solely to treat edema or ulcers or to prevent an ulcer of the lower extremity, suppliers should code them based on the patient's condition. For example, walking boots are coded L4360 and L4386 when they are used as a brace for the treatment of orthopedic conditions. However, if walking boots are used solely for the prevention or treatment of a lower extremity ulcer or edema reduction, they shall be coded A9283.

When using code A9283, there is no separate billing using addition codes. Replacement liners for devices billed with A9283 must be billed with code A9270 (noncovered item or service).

The instructions in the *Ankle-Foot, Knee-Ankle-Foot Orthoses* LCD, Documentation Requirements section, concerning the use of the GY modifier no longer apply and will be deleted in a future revision of the policy.

IMPORTANT CHANGE - KX, GA, GZ and GY Modifiers - New Uses (GEN)

Many policies use the KX modifier to indicate compliance with specified coverage criteria. The following LCDs have revised instructions on modifier use. Refer to each policy for detailed guidance.

- Automatic External Defibrillators (Effective 09/01/2009)
- Cervical Traction Devices (Effective 09/01/2009)
- Commodes (Effective 09/01/2009)
- Epoetin (Effective 09/01/2009)
- High Frequency Chest Wall Oscillation Devices (Effective 10/01/2009)
- Home Dialysis Supplies and Equipment (Effective 09/01/2009)
- Hospital Beds (Effective 10/01/2009)
- Manual Wheelchair Bases (Effective 10/01/2009)
- Negative Pressure Wound Therapy Devices (Effective 10/01/2009)
- Orthopedic Footwear (Effective 10/01/2009)
- Positive Airway Pressure Devices (Effective 09/01/2009)
- Power Mobility Devices (Effective 10/01/2009)
- Refractive Lenses (Effective 10/01/2009)
- Respiratory Assist Devices (Effective 09/01/2009)
- Therapeutic Shoes for Persons with Diabetes (Effective 08/01/2009)

The revised information is contained in the Documentation Section and outlines the use of additional modifiers to indicate that an item is statutorily noncovered or not medically necessary and whether or not a waiver of liability statement (i.e., Advance Beneficiary Notice of Noncoverage or ABN) is on file for an expected medical necessity denial.

Proper use of the KX modifier expedites claim processing. Currently, an absent modifier causes a claim denial. However, increasing numbers of claims are submitted without the modifier resulting in a growing appeals volume. If the patient meets the criteria for use of the KX modifier but the supplier forgets to include it on the claim line, currently the supplier may request a reopening of the claim. This procedure requires manual intervention by the DME MAC and is responsible for a substantial workload for the contractor.

Effective with these LCD revisions, the contractors will use the presence of a KX, GA, GZ or GY modifier to indicate whether the coverage criteria are or are not met. The DME MACs are implementing system edits that will now reject a claim line if the supplier does not include one of these modifiers as specified in each of these LCDs. If a claim line is rejected, the supplier may resubmit the claim line with the appropriate modifier. **Requesting a reopening to correct a claim that is missing one of these modifiers will no longer be an available option.**

Since the KX modifier has a differing definition depending on the LCD requirements, suppliers should review the revised LCDs carefully to understand the proper use of the KX, GA, GZ or GY modifiers for each policy.

Over the coming months, other LCDs that include use of the KX modifier will be updated to incorporate instructions for the use of the GA, GZ or GY modifiers.

PAP and RAD Devices LCDs Revised (GEN)

The *Positive Airway Pressure (PAP) devices and Respiratory Assist Devices (RAD)* local coverage determination (LCD) have been revised, effective for dates of service on or after September 1, 2009. The revised information is in the Documentation Section and outlines the use of additional modifiers to indicate that an item is not medically necessary and whether or not a waiver of liability statement (i.e., Advance Beneficiary Notice or ABN) is on file.

Over the coming months, LCDs that include use of the KX modifier will be updated to incorporate instructions for the use of the GA, GZ or GY modifiers. If the patient meets the criteria for use of the KX modifier but the supplier forgets to include it on the claim line, currently the supplier may request a reopening of the claim. This procedure requires manual intervention by the DME MAC and is responsible for a substantial workload for the contractor. Therefore, the DME MACs are implementing system edits that will reject a claim line if the supplier does not indicate that the beneficiary either meets or does not meet the requirements that are specified in each medical policy. The contractors will use the presence of a GA, GZ, or GY modifier as an indication that coverage criteria are not met. If a claim line is rejected, the supplier may resubmit the claim line with the appropriate modifier. Requesting a reopening will no longer be an option.

Since the KX modifier has a different definition depending on the LCD in question, suppliers should read the revised LCDs carefully to understand the proper use of the additional modifiers GA, GZ or GY. Further instructions and details will be published with each LCD revision.

PAP Supplier FAQ Revised - September 2009 (SPE)

Four new Questions and Answers have been added to the *Positive Airway Pressure (PAP) Devices - Supplier Frequently Asked Questions* published in July 2009 based on questions received from the provider community. The new Q & A's read as follows:

Q12: The PAP LCD states "Adherence to therapy is defined as use of PAP ≥ 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." Can you please clarify whether the ≥ 4 hours per night is continuous use or cumulative use in a 24 hour period? Would a patient who uses the device for 4 hours a night, but has a break in usage of 45 minutes still satisfy the requirements of the LCD?

A12: The ≥ 4 hours per night is based on continuous use, with allowances for short breaks (e.g., toileting).

Q13: A patient was placed on PAP therapy and during the course of their 12 week trial period they were hospitalized for two weeks. How does this impact the requirement for adherence monitoring and timing of the face-to-face follow-up evaluation?

A13: The 12 week trial period applies to PAP use in the home setting. If a patient is admitted to an inpatient hospital or skilled nursing facility (SNF), the trial period is suspended. The trial period, including the requirement for adherence monitoring and the timing of the face-to-face re-evaluation (i.e., between the 31st and 91st day) resumes when the patient returns home.

Q14: Can continued coverage of PAP therapy be extended to patients who come close to meeting the adherence metric requirements but don't quite achieve all of them in the 90 day timeframe?

A14: No. All of the requirements must be met within the 90 day time frame. CMS' national coverage determination contained specific language that benefit from PAP therapy must be demonstrated in the first 12 weeks in order to provide continued coverage beyond that time. Compliance is a major issue with CPAP; failure of therapy is often related to mask fit, humidification, ramp time, etc. Most of these issues arise in the first few days of treatment and must be aggressively addressed by the supplier and/or treating physician. Even if that takes 4-6 weeks there is still adequate time to achieve the liberal local coverage determination metric of ≥ 4 hours per night on 70% of the nights in a 30 day period.

Q19: If compliance is not documented in the first 90 days and the patient then has a new facility-based polysomnogram and face-to-face evaluation with a physician and a new trial period is begun, does a new capped rental period start?

A19: No. Standard break-in-need rules apply because there has been no change in the underlying condition that necessitates the PAP therapy. Consequently, a new capped rental period does not begin.

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

Additional questions and answers have been added to the previous publication of this FAQ. See new questions and answers 12-14 and 19.

Ordering/Treating Physician Issues

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

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

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

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

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

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

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

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

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

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

treating physician for inclusion in the patient's medical record in order to fulfill the requirement to assess therapy benefit. Consider the following example:

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

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

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

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

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

Adherence Monitoring

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

A7: The LCD was revised to include allowance for visual inspection based on comments that not all suppliers use devices that allow downloading of adherence information. Visual inspection means determining adherence by looking at information on the PAP device's display screen and documenting the values in a written report. As noted in a prior FAQ, the supplier may contact the beneficiary via telephone and ask them to read values from their device (i.e., phone-in compliance) or the supplier or physician may read the values during a home/office visit. The values must document that the patient is using the device for 4 or more hours per night for 70% of the nights in a consecutive 30-day period.

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

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

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

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

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

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

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

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

A11: No. Following the initial 3 month trial and documentation of use ≥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.

Q12: The PAP LCD states "Adherence to therapy is defined as use of PAP ≥ 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." Can you please clarify whether the ≥ 4 hours per night is continuous use or cumulative use in a 24 hour period? Would a patient who uses the device for 4 hours a night, but has a break in usage of 45 minutes still satisfy the requirements of the LCD?

A12: The ≥ 4 hours per night is based on continuous use, with allowances for short breaks (e.g., toileting).

Q13: A patient was placed on PAP therapy and during the course of their 12 week trial period they were hospitalized for two weeks. How does this impact the requirement for adherence monitoring and timing of the face-to-face follow-up evaluation?

A13: The 12 week trial period applies to PAP use in the home setting. If a patient is admitted to an inpatient hospital or skilled nursing facility (SNF), the trial period is suspended. The trial period, including the requirement for adherence monitoring and the timing of the face-to-face re-evaluation (i.e., between the 31st and 91st day) resumes when the patient returns home.

Q14: Can continued coverage of PAP therapy be extended to patients who come close to meeting the adherence metric requirements but don't quite achieve all of them in the 90 day timeframe?

A14: No. All of the requirements must be met within the 90 day time frame. CMS' national coverage determination contained specific language that benefit from PAP therapy must be demonstrated in the first 12 weeks in order to provide continued coverage beyond that time. Compliance is a major issue with CPAP; failure of therapy is often related to mask fit, humidification, ramp time, etc. Most of these issues arise in the first few days of treatment and must be aggressively addressed by the supplier and/or treating physician. Even if that takes 4-6 weeks there is still adequate time to achieve the liberal local coverage determination metric of ≥ 4 hours per night on 70% of the nights in a 30 day period.

Reimbursement Issues

Q15: 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?

A15: 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).

Q16: 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?

A16: 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.

Q17: 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?

A17: 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."

Q18: If a patient is put on a RAD device with less than 30 day left in the initial 91 day period, the LCD indicates that the patient will be given to 120 days after the initiation of PAP therapy to document adherence. If the patient had a face to face exam in the 31 to 91 day period while on a CPAP device, must they have another face to face exam after they are on RAD? Certainly if they did not have a face to face exam in the 31 to 90 days we understand that one would need to be done before the 120th day.

A18: 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.

Q19: If compliance is not documented in the first 90 days and the patient then has a new facility-based polysomnogram and face-to-face evaluation with a physician and a new trial period is begun, does a new capped rental period start?

A19: No. Standard break-in-need rules apply because there has been no change in the underlying condition that necessitates the PAP therapy. Consequently, a new capped rental period does not begin.

Q20: 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?

A20: Yes, it would be considered a "blanket" ABN if the notice was presented at the beginning of therapy. The supplier may however, after day 60 following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not yet met the policy criteria for continued coverage. This ABN should advise the beneficiary that if, by the 90th day of therapy, they do not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face to face evaluation), Medicare may deny their subsequent claim(s) and that the beneficiary will be liable for payment.

Q21: What can a supplier do if the patient does not get in to see the treating physician within the 31st-91st day?

A21: 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.

Q22: 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?

A22: The NCD and LCD require that prior to initiating PAP therapy, the patient has a clinical evaluation and sleep test. There is a sound clinical rationale for this specific sequence of events; therefore, a face-to-face evaluation performed after the sleep test or after the initiation of PAP therapy would not meet the coverage requirements and a KX modifier must not be added to the claim. Suppliers may obtain an ABN to inform the beneficiary that the PAP device will not be covered since the coverage requirements were not met.

Results Of Widespread Prepayment Review Of Claims For HCPCS Code E2402 (Negative Pressure Wound Therapy Electrical Pump, Stationary Or Portable) (SPE)

The DME MAC A Medical Review Department recently concluded three quarterly widespread reviews of E2402 from October 2008 through June 2009.

The results of the quarterly review of the claims from October 1, 2008 through December 31, 2008 identified twenty-nine (29) claims submitted by eight (8) suppliers, of which eight (8) claims were denied (27.59%). This resulted to an overall Charge Denial Rate of 25.60%.

The results of the quarterly review of the claims from January 1, 2009 through March 31, 2009 identified forty-five (45) claims submitted by thirteen (13) suppliers, of which eighteen (18) claims were denied (40%). This resulted to an overall Charge Denial Rate of 36.70%.

The results of the quarterly review of the claims from April 1, 2009 through June 30, 2009 identified eighty-one (81) claims submitted by twenty-four (24) suppliers, of which twenty-nine (29) were denied (35.80%). This resulted to an overall Charge Denial Rate of 36.27%.

The following are the most common reasons for denial:

- The equipment was the same or similar to an equipment already being used
- Patient eligibility (e.g., patient joined HMO)
- Claim not payable under Jurisdiction A
- No response to medical records request
- The equipment was provided while the patient is in the nursing home
- The equipment was considered not reasonable and necessary (e.g., no medical updates in patient's medical records, medical records lacking in subsequent wound assessment by the medical professional from the initial assessment of the wound, treatment notes by RN not signed.)

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

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

Suppliers are reminded to reference the following publications for documentation requirements for HCPCS code E2402, the *DME MAC A Supplier Manual* at **http://www.medicarenhic.com/dme/suppmandownload.shtml** and the *Negative Pressure Wound Therapy Pumps (L11500)* LCD located at **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**. These are available on the DME MAC A Web site at: **http://www.medicarenhic.com/dme**

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

DME MAC A continues its widespread, pre-payment review of Power Wheelchairs, HCPCS K0823. This review was initiated based on the result of the widespread pre-payment probe review initially performed by TriCenturion, which determined the Charge Denial Rate (CDR) to be 89.75% for Jurisdiction A. Subsequently, all HCPCS K0823 claims continued to be subjected to pre-payment review.

DME MAC A recently concluded subsequent quarterly widespread pre-payment reviews. This process involves the selection of random claims, for which an ADR (automated development response) letter is issued to the supplier requesting medical documentation. The documentation received is reviewed by clinical staff for compliance with Medicare rules and regulations.

The results of the quarterly review for claims from October 1, 2008 through December 31, 2008, identified the following CDR:

- This review involved 105 claims submitted by 30 suppliers, of which, 34 claims were allowed and 71 were denied (67.62%). This resulted in an overall Charge Denial Rate of **67.62%**, calculated by dividing the denied allowed amount ($285,682.70) by the total reviewed allowance amount ($422,488.50).

The results of the quarterly review for claims from January 1, 2009 through March 31, 2009 identified the following CDR:

- This review involved 348 claims submitted by 125 suppliers, of which 129 claims were allowed and 219 were denied (69.93%). This resulted in an overall Charge Denial Rate of **62.78%**, calculated by dividing the denied allowed amount ($860,235.86), by the total reviewed allowance amount ($1,370,260.30).

These reviews determined the primary reasons for denials were:

- Mobility-related activities of daily living (MRADLs) limitations are not provided in detail. Documentation should identify specific limitations and clearly indicate what they can and cannot complete in terms of MRADLs.

- Beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home in order to perform his/her MRADLs during a typical day. Documentation should provide details, such as;
  - Strength levels and degrees of range of motion (ROM) of the beneficiary's upper and lower extremities.
  - Endurance level.
  - Pain rating and how performance of MRADLs impacts this pain rating.

- Supplier Generated Reports:
  - Face-to-Face mobility examination forms do not record a complete medical examination, they do not provide enough detail information to adequately describe the medical necessity for the power mobility device.
  - Many of the face-to-face examination and medical necessity/justification letters are check mark box template forms which are vague in the areas addressed with no detailed objective documentation to support the items marked. Data on forms have also been noted to conflict from page to page and/or document to document.

- Sequence of Events have been out of order:
  - Detailed product description document is dated prior to seven element order / prescription.
  - Seven element order / prescription, signed by physician but not dated.
  - Letter of medical necessity / justification dated after detail product description.

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

Suppliers are reminded to reference the following publications for documentation requirements. The January 11, 2008 educational article *Power Mobility Devices Billing Reminder* located at **http://www.medicarenhic.com/dme/articles/011108_pmd.pdf** and the *Power Mobility Devices (L21271)* LCD which can be found on the DME MAC A Web site at **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

Therapeutic Shoes - Withdrawal of Policy Article (GEN)

A revision of the *Therapeutic Shoes for Persons with Diabetes* Policy Article was recently released. The effective date was listed as August 1, 2009. That version of the Policy Article is being withdrawn. The current version of the Policy Article which has an effective date of October 1, 2008 remains in effect until a new revised Policy Article is published.

Widespread Prepayment Probe for Oxygen and Oxygen Equipment LCD (L11486) (OXY)

DME MAC A will be initiating a widespread prepayment medical review of claims for oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate (E1390) and portable gaseous oxygen system, rental: includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing (E0431). This review is being initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) contractor.

Suppliers will be sent a documentation request for information listed below. The requested documentation must be returned within 30 days from the date of the letter to avoid claim denials.

Documentation should include the following per LCD L11468 - Oxygen and Oxygen Equipment:

- Documentation of verbal order (if item is dispensed based on a verbal order)
- Valid written order
- Copy of qualifying arterial blood gas (ABG) or pulse oximetry report referenced on the CMN
- Certificate of Medical Necessity (CMS-484)
- Proof of delivery
- Medical record information from treating physician to support that beneficiary is continuing to require, use and benefit from oxygen therapy equipment

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy article. Suppliers can review the Oxygen and Oxygen Equipment LCD on the DME MAC A Web site at: **http://www.medicarenhic.com/dme**

A common problem in these reviews in missing or incomplete records. Please ensure when submitting documentation requests that all requested information is included with your file and respond in a timely manner.

DMEPOS Supplier Accreditation
Deadline is September 30, 2009

Second Quarter 2009 - Top Claim Submission Errors (GEN)

A claim submission error (CSEs) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for April through June 2009, are provided in the following table.

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 - Invalid Procedure Code and/or Modifier	309,267	The procedure code, modifier, or procedure code and modifier combination is invalid.
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	115,590	The Tax ID (Employer Identification Number/Social Security Number) that was submitted does not match what is on file with the NPPES or the National Supplier Clearinghouse (NSC).
C003 - Billing NPI Not Found on Crosswalk	105,943	There is no link between the NPI that was submitted and a PTAN/NSC.
C095 - Diagnosis Code Invalid - Pointer 1	63,434	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
B108 - Billing provider not authorized for submitter	57,332	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C143 - Ordering Provider ID Qualifier Invalid	54,218	The Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line.
C044 - Subscriber Primary ID Invalid	50,385	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C171 - Capped Rental - Modifier Missing	41,605	The item (whether for purchase or rental) is classified as a capped rental item (or possibly a pen pump item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.
C180 - Service Date Greater than Receipt Date	36,448	The date of service entered in the claim is greater than the date the claim was submitted.
C147 - Secondary ID Invalid	31,053	The Ordering Provider secondary identifier is invalid.

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the second quarter of 2009. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from April through June 2009.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	5,912
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	2,904
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	2,510
CO 16 N286 Missing / incomplete / invalid referring provider primary identifier.	**Item 17A** - Physician UPIN (Unique Physician Identifier Number) submitted in error. Physician NPI must be submitted in Item 17B.	2,306
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	2,027
CO 16 N257 Missing / incomplete / invalid billing provider/supplier primary identifier.	**Item 33** - Provider Transaction Access Number (PTAN) number submitted in error. Must submit National Provider Identifier (NPI).	1,457
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,429
CO 16 N280 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid pay to provider primary identifier.	**Item 33** - NPI bypass logic rejection - Invalid NPI/PTAN pair on the crosswalk file.	1,287
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid ordering provider primary identifier.	**Item 17B** - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician.	1,235
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	1,214

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

Change in Address Process for Paper Claim Submission (GEN)

DME MAC Jurisdiction A continuously strives to improve our processes and enhance your business experience. Beginning November 30, 2009 we are reducing the number of PO Box addresses where paper claims may be submitted. There will only be one address for submitting all paper claims.

The following PO Boxes will be eliminated, effective November 30, 2009:

- P.O. Box 9145 - Drug Claims
- P.O. Box 9147 - Mobility Support
- P.O. Box 9148 - Oxygen
- P.O. Box 9149 - PEN

The following address will remain and will be the only available address for paper claim submission. If you are now using this address, please continue. If not, it is very important that you do, effective November 30, 2009, to avoid any delays in our receipt of your claims.

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

Accreditation and Surety Bond Deadline Reminders (GEN)

In order to obtain or retain your Medicare Part B billing privileges, all DMEPOS suppliers (except for exempted professionals and other persons as specified by the Secretary of the DHHS) must comply with the Medicare program's supplier standards and quality standards and become accredited. A DMEPOS supplier's billing privileges will be revoked on or after **October 1, 2009**, if the DMEPOS supplier fails to obtain accreditation unless the DMEPOS supplier submits a voluntary termination to the NSC by **September 30, 2009**.

DMEPOS suppliers (except for those specified as exempt by CMS) must submit to the NSC a $50,000 surety bond for each assigned NPI no later than October 2, 2009. In addition, a DMEPOS supplier enrolling a new practice location must submit to the NSC a new surety bond or an amendment or rider to the existing bond, showing the new practice location is covered by an additional base surety bond of $50,000. Suppliers who have had certain adverse legal actions imposed against them may be required to post a higher bond amount.

Additional information on accreditation and surety bonds is available at: **http://www.cms.hhs.gov/MedicareProviderSupEnroll**

CERT On-Line Quiz Results (GEN)

The Outreach & Education Team was pleased to provide the Comprehensive Error Rate Testing (CERT) on-line quiz to help assist providers with understanding the CERT program. After reviewing the final reports of the quiz, it has come to our attention there are many misconceptions of the CERT functional procedures.

The top five incorrectly answered quiz questions deal with what the purpose of the CERT program is and how to respond appropriately. The CERT program was developed to measure and improve the quality and accuracy of claim submission, processing, and payment of the Medicare program. This is to ensure the Medicare Trust Fund is protected as well as provide quality customer service to the provider community. The CERT Documentation Contractor (CDC) is responsible for requesting and receiving medical records for a CERT review. Suppliers should submit this documentation as soon as possible but it **MUST** be received within 75 days of the initial request letter.

Suppliers are notified when one or more of their claims are chosen for a CERT review by an initial request letter. The initial letter is followed by a series of letters and phone calls in the event that the CDC does not receive the requested documentation within 25 days of the initial letter.

The CDC has requested that providers fax CERT requested medical records/documentation to the CERT Fax line which is: 240-568-6222

To continue to enhance our educational efforts, DME MAC Jurisdiction A would like to remind suppliers of the CERT section of our Web site. Information in this section includes; CERT FAQs, CERT Documentation Checklist, CERT contacts and the newly developed CERT & You Newsletter.

The CERT & You Newsletter provides contact information, updates about the CERT program, helpful links and tools as well as CERT Review examples which were cited for errors. DME MAC A feels this is a great benefit to providers to help guide them in understanding what type of medical documentation is required by the CERT.

Please visit the following link for a description of the CERT Program: **http://www.medicarenhic.com/dme/dmerc_cert.shtml**

Claims Processing Change for Capped Rental Modifiers (KH, KI, and KJ) (GEN)

Over the years, NHIC, Corp. DME MAC A has continued to correct claims with the improper use of the KH, KI, and KJ modifiers on capped rental items and PEN pumps. For claims submitted with the inappropriate capped rental "K" modifier, NHIC has manually intervened to correctly append the appropriate "K" modifier to allow for proper processing. This notice is to advise that effective with claims received on or after September 18, 2009, NHIC will no longer provide these corrections and will reject claims that are not billed with the appropriate "K" modifier with ANSI reason code 182, remark code N56.

When billing a capped rental item or a PEN Pump, the "KH" modifier shall only be used for the first month of billing. The "KI" modifier shall only be used for the second and third months of billing. The "KJ" modifier shall then be used for the remainder of the capped rental period (months 4-13), and the PEN pump rental period (months 4-15). All other applicable modifiers must also be included when billing. Please reference the link below for a complete list of modifiers:
http://www.medicarenhic.com/dme/medical_review/mr_hcpcs/2009_hcpcs_modifiers.pdf

Additionally, if the capped rental item was previously provided to a Medicare beneficiary and a new rental period is now being requested, a narrative must be added that clearly explains why the item is being replaced to avoid unnecessary rejections. NHIC recommends that you use our Interactive Voice Response (IVR) system at 1-866-419-9458 to verify if equipment was previously provided. Effective with claims received on or after September 18, 2009, NHIC will begin rejecting claims with modifier "KH" when a previous initial capped rental month is on file and the claim is submitted without a narrative that clearly supports a new rental period. These claims will reject with ANSI reason code 182, remark code N56.

If a rejected claim occurs due to either situation outlined above (the incorrect billing of the "K" modifier or missing narrative), the claim must be corrected with the proper information and re-submitted. This correction will not be handled through the re-openings process. NHIC strongly recommends suppliers check the IVR to ensure the first month's claim (KH modifier) was appropriately adjudicated prior to billing subsequent rental months (KI and KJ modifiers).

DME MAC Jurisdiction A Completes Educational Symposiums (GEN)

The DME MAC Jurisdiction A Provider Outreach & Education (POE) Team completed two very successful educational symposiums in August and September. Jurisdiction A partnered with several Medicare Contractors (CBIC, CERT, NSC, RAC, J14 MAC, etc.) as well as state and national DMEPOS associations in an effort to make these events as informative and productive as possible. Approximately 500 attendees participated in these full day events. For a nominal fee, attendees were provided with breakfast, lunch, breaks, and vendor interaction throughout the day. In addition, attendees had the opportunity to register for three different break-out sessions by choosing from 11 different topics.

Representatives from the Centers for Medicare and Medicaid Services (CMS) were the keynote speakers for each symposium providing presentations that included information on Zone Program Integrity Contractors (ZPICs), Recovery Audit Contractors (RACs), and Fraud & Abuse. Dr. Paul Hughes, the DME MAC Jurisdiction A Medical Director, conducted a lunch presentation focusing on updates and changes affecting the DMEPOS program.

The entire POE staff would like to thank all attendees, speakers, and exhibitors for their enthusiastic participation. Your dedication and personal involvement is what makes the program successful.

Jurisdiction A DME MAC Reopening Commonly Asked Questions (GEN)

What is a reopening?
A reopening is the process that allows suppliers to correct clerical errors or omissions without having to request a formal appeal. Clerical errors or minor errors are limited to errors in form and content. Omissions do not include failure to bill for certain items or services.

How long do I have to request a reopening?
A party may request a contractor reopen and revise its initial determination or redetermination under the following conditions:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause

You must wait to make contact with the Reopening Department until after you have received a Remittance Advice (RA). No action can be taken until a final claim determination is rendered.

How do I request a reopening?
You can request a reopening in writing through Fax (include the fax cover sheet and fax to: 781-741-3914 or mail to: NHIC Corp. DME MAC, Attn: Reopenings, PO Box 9175 Hingham, MA 02043 or you can request a telephone reopening at: 317-595-4371

How long does it take the DME MAC to process my reopening?
For those reopenings requested by a party that the contractor agrees to reopen, the contractor shall complete the reopening action 60 days from the date of receipt of the party's reopening request.

Reminders:

- Suppliers should not submit a duplicate reopening request within the 60 days of the initial request
- Do not fax redeterminations or correspondence to the reopening fax line

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Quarterly Provider Update (GEN)

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

DME MAC A ListServes (GEN)

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

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

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

Supplier Manual News (GEN)

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

Updates/Corrections Made:
In July of 2009 **chapters 1, 2, 3, 5 and 8** of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

The Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) for Jurisdiction A will continue to offer our quarterly bulletin, the DME MAC Jurisdiction A Resource, in electronic format via our Web site, where copies can be printed free of charge. To access the bulletin, go to the "Publications" section of the DME MAC A Web site at **http://www.medicarenhic.com/dme/dme_publications.shtml**. To be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, subscribe to the DME MAC A ListServes, our electronic mailing lists. To subscribe, visit **http://www.medicarenhic.com/dme/** and click on "**ListServe Sign-Up**".

For Suppliers without Internet Access: If you do not have Internet access and require the bulletin via hardcopy or CD-ROM*, you may subscribe to it for a fee. The annual subscription fee is $65.00 for hardcopy and $172.00 for CD-ROM. ***This subscription includes the four quarterly bulletins published during the calendar year of 2010 - March, June, September, and December.*** Complete this form and submit with payment, via check only, to the address listed below.

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75 Sgt William B Terry Drive
Hingham, MA 02043

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

For Your Notes

Beginning November 30, 2009 there will only be one address for submitting all paper claims to DME MAC A

(For more information see the article on page 54)

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

Written Inquiries

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

Written Inquiry FAX: 781-741-3118

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

Note: *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

Redetermination Requests Fax: 781-741-3118

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

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:

Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

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

LCD Reconsiderations Mailing Address:

Same as Draft LCDs Comments

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

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:

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

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

Email Address: **ngs.CEDIHelpdesk@wellpoint.com**

DME MAC Jurisdiction A Resource

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

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Publication Information

NHIC, Corp. is the contractor for the Jurisdiction A DME MAC serving all of Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

Visit the following Web sites for more information:

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

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

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

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