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

Table of Contents

December 2010
Number 18

Billing/Finance

General Information

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

Table of Contents

Medical Review

Outreach and Education

Legend

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

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

Attention: Electronic Trading Partners (CEDI Message) (GEN)

Due to the change in the timely filing limits for Medicare fee-for-service claims, if you need a claim receipt date prior to January 1, 2011, you must have your claims submitted to Common Electronic Data Interchange (CEDI) no later than 3:00 p.m. (ET) on December 30, 2010.

Because December 31, 2010 is a holiday for CEDI and the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), electronic submitters must know the following:

- Claims submitted to CEDI before 3:00 p.m. (ET) on December 30, 2010 will receive a date of receipt of December 30, 2010.
- Claims submitted to CEDI after 3:00 p.m. (ET) on December 30, 2010 and before 5:00 p.m. (ET) on January 3, 2011 will receive a date of receipt of January 3, 2011.

Timely Filing Requirements for Medicare Fee-For-Service Claims (201004-02)
On March 23, 2010, President Obama signed into law the *Patient Protection and Affordable Care Act* (PPACA), which amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program.

The time period for filing Medicare FFS claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the *Social Security Act* and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44. Section 6404 of the PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service.

As a result of the PPACA, the timely filing limits for submitting claims for Medicare fee-for-service (FFS) reimbursement have changed.

- Claims with dates of service prior to 10/01/2008 are past timely filing for Medicare.
- Claims with dates of service 10/01/2008 - 12/31/2009 must be submitted to Medicare by 12/31/2010.
- Claims with dates of service 01/01/2010 and after have to be submitted to Medicare within one year after the date of service.

Section 6404 of the PPACA also permits the Secretary to make certain exceptions to the one-year filing deadline. At this time, no exceptions have been established. However, proposals for exceptions will be specified in future proposed rulemaking.

Please be on the alert for more information pertaining to the *Patient Protection and Affordable Care Act*.

2011 Annual Update of Healthcare Common Procedure Code System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update (MM7159) (GEN)

MLN Matters® Number: MM7159
Related CR Release Date: September 10, 2010
Related CR Transmittal #: R2048CP
Related Change Request (CR) #: 7159
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 7159 which provides the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

What You Need to Know

Physicians and providers are advised that, by the first week in December 2010, new code files will be posted at **http://www.cms.gov/SNFConsolidatedBilling/** on the Centers for Medicare & Medicaid Services (CMS) web site. Note that this site will include new Excel® and PDF format files. It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update listed at **http://www.cms.gov/SNFConsolidatedBilling/** on the CMS web site in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the *Medicare Claims Processing Manual* (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at **http://www.cms.gov/manuals/downloads/clm104c06.pdf** on the CMS web site. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information

The official instruction, CR 7159, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2048CP.pdf** on the CMS web site.

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

Claim Status Category and Claim Status Codes Update (MM7158) (GEN)

MLN Matters® Number: MM7158
Related CR Release Date: September 17, 2010
Related CR Transmittal #: R2049CP

Related Change Request (CR) #: 7158
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

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

Provider Action Needed

This article, based on CR 7158, 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 along with the 277 Health Care Claim Acknowledgement updated during the October 2010 meeting of the national Code Maintenance Committee and code changes approved at that meeting are to be posted at **http://www.wpc-edi.com/content/view/180/223/** on or about November 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on January 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background
The *Health Insurance Portability and Accountability Act* 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 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. These codes explain the status of submitted claims. 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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

The official instruction, (CR 7158), issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2049CP.pdf** on the CMS web site

---

Implementation of Section 2902 of the Affordable Care Act for Indian Health Service (IHS) Part B Services and All Inclusive Rate (AIR) Billing for Return Visits (MM6908) (GEN)

MLN Matters® Number: MM6908
Related CR Release Date: October 28, 2010
Related CR Transmittal #: R2075CP
Related Change Request (CR) #: 6908
Effective Date: January 1, 2010
Implementation Date: January 28, 2011

Provider Types Affected
This article is for IHS providers receiving payment under the AIR payment methodology for Part B hospital outpatient services.

Provider Action Needed
This article is based on Change Request (CR) 6908 which clarifies billing for return visits to IHS providers under the AIR payment methodology. See the Background and Additional Information Sections of this article for further details regarding this clarification.

CR 6908 also implements Section 2902 of The *Affordable Care Act*, which extends indefinitely Section 630 of The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA), retroactive to January 1, 2010. *MLN Matters*® article SE0930 contains more details on this extension of Section 630 of the MMA. The article is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE0930.pdf** on the Centers for Medicare & Medicaid Services (CMS) web site.

Background
CR 6908 updates the *Medicare Claims Processing Manual* (Chapter 19, Section100.5.1) to clarify that, while at least one face-to-face encounter with a physician (or non-physician practitioner) is required for an initial visit to count as a billable AIR encounter, the same is not always true of return visits to obtain follow-up care ordered by the physician (or non-physician practitioner) during the initial visit.

CR 6908 further states that it is appropriate for a return encounter to be billed on the date the procedure or test is furnished and for the provider to receive an additional AIR payment (even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit) if:

- A physician (or non-physician practitioner) orders a specific procedure or test which cannot be furnished until a later date after the date of the initial visit with the physician (or non-physician practitioner); and
- The procedures or tests are medically necessary.

Examples of medically necessary reasons for return visits would include a requirement that:

1. The beneficiary fast for 12 hours prior to an ordered test; or
2. A chest X-ray be provided two weeks following the initiation of antibiotic treatment for pneumonia.

Also, a return visit would be considered medically necessary if a beneficiary must return on another day for a medically necessary test ordered during an initial visit because the test cannot be performed on the day it is ordered due to provider or patient constraints that cannot be overcome.

Additional Information
The official instruction, CR 6908, issued to your carrier, DME MAC and/or A/B MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2075CP.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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Implementation of the PWK (Paperwork) Segment for X12N Version 5010 (MM7041) (GEN)

MLN Matters® Number: MM7041 - Revised
Related CR Release Date: November 10, 2010
Related CR Transmittal #: R806OTN
Related Change Request (CR) #: 7041
Effective Date for Providers: July 1, 2011
Implementation Date: July 5, 2011

Note: *This article was revised on November 12, 2010, to reflect a revised CR 7041 issued on November 10, 2010. The effective and implementation dates have been changed. In addition, the CR transmittal number, release date, and the Web address for accessing CR 7041 were revised. All other information is the same.*

Provider Types Affected
This article is for 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) 7041 which announces the implementation of the PWK (paperwork) segment for X12N Version 5010. Be sure your billing staff is aware of these changes.

Background
Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete *Health Insurance Portability & Accountability Act of 1996* (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the "linkage" between electronic claims and additional documentation which is needed for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key Points for Medicare Billers:

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at **http://www.cms.gov/Transmittals/downloads/R763OTN.pdf** on the CMS web site.

- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.

- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.

- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at **http://www.cms.gov/Transmittals/downloads/R806OTN.pdf** on the CMS web site.

January 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7188) (DRU)

MLN Matters® Number: MM7188
Related CR Release Date: October 15, 2010
Related CR Transmittal #: R2067CP
Related Change Request (CR) #: 7188
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected
This article is for 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) 7188 and instructs Medicare contractors to download and implement the January 2011 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2010, July 2010, April 2010, and January 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2011, with dates of service January 1, 2011, through March 31, 2011. See the Background and Additional Information Sections of this article for further details regarding these changes.

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

The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
January 2011 ASP and ASP NOC files	January 1, 2011 through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and ASP NOC files	January 1, 2010, through March 31, 2010

NOTE: *The absence or presence of a Healthcare Common Procedure Coding System (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
If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

The official instruction (CR 7188) issued to your Medicare MAC, carrier, and/or FI may be found at **http://www.cms.gov/Transmittals/downloads/R2067CP.pdf** on the CMS web site.

National Modifier and Condition Code to Identify Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico (MM7087) (GEN)

MLN Matters® Number: MM7087
Related CR Release Date: August 6, 2010
Related CR Transmittal #: R2021CP
Related Change Request (CR) #: 7087
Effective Date: April 20, 2010
Implementation Date: January 3, 2011

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries related, in whole or in part, to the 2010 oil spill in the Gulf of Mexico.

Provider Action Needed
This article is based on Change Request (CR) 7087 which identifies a new modifier and a new condition code that must be used to identify items or services related to the 2010 oil spill in the Gulf of Mexico. Be sure your billing staff is aware of these changes. **You should begin to place the modifier or condition code on claims submitted as of January 3, 2011.**

Background
As a result of the oil spill in the Gulf of Mexico, the Centers for Medicare & Medicaid Services (CMS) plans to monitor the potential health and cost impacts of the oil spill on Medicare beneficiaries, in both the short and long-term. In order to ensure that such health care services and costs are properly identified, CMS is requiring that every Medicare Fee-For-Service claim be specifically identified if it is for an item or service furnished to a Medicare beneficiary, where the provision of such item or service is related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico (hereafter referred to as the "Gulf oil spill") and/or circumstances related to such oil spill, including but not limited to subsequent clean-up activities.

Claims from physicians, other practitioners, and suppliers must be annotated with the modifier "CS" for each line item where the item or service is so related. Similarly, claims from institutional billers must be annotated with a condition code of "BP" when the entire claim is so related or with the "CS" modifier for each relevant line item when only certain line items are so related. The modifier and condition code are to be used for claims with dates of service on or after April 20, 2010.

The long description of the CS modifier is as follows: "Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities."

The short description of the CS modifier is: "Gulf Oil Spill Related".

The title of the BP condition code is "Gulf oil spill related" and its definition is as follows: "This code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities."

Note: *CMS requests provider, physician and supplier assistance in identifying previously processed claims related to an illness, injury or condition caused or exacerbated either directly or indirectly by the 2010 Gulf oil spill. CMS encourages providers, physicians and suppliers to contact their Medicare contractor to identify services or claims - submitted and processed prior to the creation of the Gulf oil spill modifier and condition code - that should have the CS modifier and/or the BP condition code appended.*

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

The official instruction (CR7087) issued to your Medicare MAC, carrier and/or FI is available at **http://www.cms.gov/Transmittals/downloads/R2021CP.pdf** on the CMS web site.

Outpatient Therapy Cap Values for CY 2011 (GEN)

MLN Matters® Number: MM7107
Related CR Release Date: October 22, 2010
Related CR Transmittal #: R2073CP
Related Change Request (CR) #: 7107
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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 therapy services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7107, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for Calendar Year (CY) 2011. No change to the exceptions process is anticipated, if it should be extended into 2011. Be sure billing staff is aware of the updates.

Background
The *Balanced Budget Act of 1997* set therapy caps, which change annually, for Part B Medicare patients. The *Deficit Reduction Act of 2005* allowed CMS to establish a process for exceptions to therapy caps for medically necessary services. The *Affordable Care Act* extended exceptions to therapy caps through December 31, 2010.

Therapy caps for 2011 will be $1870. The exceptions process will continue unchanged for the time frame directed by the Congress.
Note that the limitations apply to outpatient services and do not apply to Skilled Nursing Facility (SNF) residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services billed under the Home Health PPS, inpatient hospitals or the outpatient department of hospitals, including critical access hospitals.

Additional Information
The official instruction, CR 7170, issued to your FI, carrier, A/B MAC, or RHHI regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2073CP.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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

Additional information concerning outpatient therapy services may be found at **http://www.cms.gov/therapyservices** on the CMS web site.

Reasonable Charge Update for 2011 for Splints, Casts, and Certain Intraocular Lenses (MM7225) (O&P)

MLN Matters® Number: MM7225
Related CR Release Date: November 19, 2010
Related CR Transmittal #: R2100CP

Related Change Request (CR) #: 7225
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Provider Action Needed
Change Request (CR) 7225, from which this article is taken, instructs your carriers, FIs, and MACs how to calculate reasonable charges for the payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Make sure your billing staff is aware of these changes.

Background
Payment continues to be made on a reasonable charge basis for splints, casts, and for intraocular lenses implanted (codes V2630, V2631, and V2632) in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Beginning January 1, 2011, reasonable charges will no longer be calculated for payment of home dialysis supplies and equipment for Method II End Stage Renal Disease (ESRD) patients. Section 153 of *Medicare Improvements for Patients and Providers Act* (MIPPA) amended section 1881(b) of the Act to require the implementation of an ESRD bundled payment system effective January 1, 2011. The ESRD prospective payment will provide an all-inclusive single payment to ESRD facilities (i.e. hospital-based providers of services and renal dialysis facilities) that will cover all the resources used in providing outpatient dialysis treatment, including dialysis supplies and equipment that are currently separately payable to Method II DME suppliers.

CR 7225 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501. The Inflation Indexed Charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. The 2011 payment limits for splints and casts will be based on the 2010 limits that were announced in CR 6691 last year, increased by 1.1 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2010. The IIC update factor for 2011 is 1.1 percent.

A list of the 2011 payment limits for splints and casts are as follows:

Code	Payment Limit	Code	Payment Limit	Code	Payment Limit	Code	Payment Limit	Code	Payment Limit
A4565	$7.84	Q4010	$17.75	Q4020	$6.62	Q4030	$69.33	Q4040	$18.76
Q4001	$44.60	Q4011	$3.94	Q4021	$6.14	Q4031	$13.17	Q4041	$18.22
Q4002	$168.58	Q4012	$8.88	Q4022	$11.08	Q4032	$34.66	Q4042	$31.11
Q4003	$32.04	Q4013	$14.36	Q4023	$3.09	Q4033	$24.57	Q4043	$9.12
Q4004	$110.92	Q4014	$24.21	Q4024	$5.54	Q4034	$61.10	Q4044	$15.56
Q4005	$11.81	Q4015	$7.18	Q4025	$34.44	Q4035	$12.28	Q4045	$10.58
Q4006	$26.62	Q4016	$12.10	Q4026	$107.54	Q4036	$30.56	Q4046	$17.02
Q4007	$5.92	Q4017	$8.30	Q4027	$17.23	Q4037	$14.99	Q4047	$5.28
Q4008	$13.31	Q4018	$13.23	Q4028	$53.78	Q4038	$37.55	Q4048	$8.51
Q4009	$7.89	Q4019	$4.16	Q4029	$26.34	Q4039	$7.51	Q4049	$1.93

Additional Information
The official instruction, CR 7225 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2100CP.pdf** on the CMS web site.

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

Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception (MM6677) (GEN)

MLN Matters® Number: MM6677 - Revised
Related CR Release Date: November 6, 2009
Related CR Transmittal #: R590OTN

Related Change Request (CR) #: 6677
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Note: *This article was revised on September 21, 2010 to remove a reference to the National Competitive Billing Indicator from the fourth bullet point on page 2. Providers are not responsible for coding that indicator. All other information remains the same.*

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

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

Key Points of CR6677

- Hospitals may furnish walkers and related accessories to their patients on the date of discharge whether or not the hospital has a contract under the DMEPOS Competitive Bidding Program.

- Separate payment is not made for walkers and related accessories furnished by a hospital **on the date of admission** as payment for these items is included in the Part A payment for inpatient facility services.

- Hospitals as defined below may furnish walkers and related accessories to their patients for use in the home on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier.

- To be paid for walkers and accessories as a non-contract supplier, hospitals should **use the modifier "J4"** on the claim line in combination with the following **HCPCS codes: A4636, A4637, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0154, E0155, E0156, E0157, E0158, and E0159.**

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

Background

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

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

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

Additional Information

If you have questions, please contact your Medicare DME/MAC, FI or A/B MAC at their toll-free number which may be found at: **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site. The official instruction (CR6677) issued to your Medicare FI, DME/MAC, or A/B MAC is available at **http://www.cms.gov/Transmittals/downloads/R590OTN.pdf** on the CMS web site.

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

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

Update to Medicare Deductible, Coinsurance and Premium Rates for 2011 (MM7224) (GEN)

MLN Matters® Number: MM7224
Related CR Release Date: November 19, 2010
Related CR Transmittal #: R65GI
Related Change Request (CR) #: 7224
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Impact on Providers
This article is based on Change Request (CR) 7224 which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2011.

Background
2011 Part A - Hospital Insurance (HI)
A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness , he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

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

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness . **The 2011 inpatient deductible is $1,132.00**. The coinsurance amounts are shown below in the following table:

Hospital Coinsurance		Skilled Nursing Facility Coinsurance
Days 61-90	**Days 91-150 (Lifetime Reserve Days)**	**Days 21-100**
$283.00	$566.00	$141.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, The *Social Security Act* provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium. Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2011 Part A premiums are as follows:

Voluntary Enrollees Part A Premium Schedule for 2011	
Base Premium (BP)	$450.00 per month
Base Premium with 10% Surcharge	$495.00 per month
Base premium with 45% Reduction (for those with 30-39 quarters of coverage)	$248.00 (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	$272.80 per month

2011 Part B - Supplementary Medical Insurance (SMI)
Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2011, the standard premium for SMI services is $115.40 a month; the deductible is $162.00 a year; and the coinsurance is 20%. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 7224, which is available at **http://www.cms.gov/Transmittals/downloads/R65GI.pdf** on the Centers for Medicare & Medicaid Services (CMS) web site.

Additional Information
The official instruction, CR 7224, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R65GI.pdf** on the CMS web site.

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

Fee Schedule Updates (GEN)

The 2010 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:

The following Fee Schedules have been added:
- 4th Quarter 2010 Jurisdiction A DME MAC Fee Schedule
- 4th Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2010 Oral Anticancer Drug Fees

The following Fee Schedules have been revised:
- 3rd Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2009 Average Sales Price Medicare Part B Drug Pricing File

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.

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

2010 - 2011 Seasonal Influenza (Flu) Resources for Health Care Professionals (SE1031) (GEN)

MLN Matters Number: SE1031 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on November 29, 2010, to include a reference to MLN Matters® article MM7234 (New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines). All other information is the same.*

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

Provider Action Needed
- Keep this Special Edition *MLN Matters* article and refer to it throughout the 2010 - 2011 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction
Annual outbreaks of seasonal flu typically occur from the late fall through early spring. Typically, 5 to 20 percent of Americans catch the seasonal flu, with about 36,000 people dying from flu-related causes.1 Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

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

Get the Flu Vaccine, Not the Flu!

Unlike last flu season patients needed to get both a seasonal vaccine and a separate vaccine for the H1N1 virus, this season, a single seasonal flu vaccine will protect your patients, your staff, and yourself.

The seasonal flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

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

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

1. **MLN Matters Seasonal Influenza Articles**
   - **MM7120**: *Influenza Vaccine Payment Allowances - Annual Update for 2010-2011 Season* at **http://www.cms.gov/MLNMattersArticles/downloads/MM7120.pdf** on the CMS web site.
   - **SE1026**: *Important News About Flu Shot Frequency for Medicare Beneficiaries* at **http://www.cms.gov/MLNMattersArticles/downloads/SE1026.pdf** on the CMS web site.

- **MM7124**: *2010 Reminder for Roster Billing and Centralized Billing for Influenza and Pneumococcal Vaccinations* at **http://www.cms.gov/MLNMattersArticles/downloads/MM7124.pdf** on the CMS web site.

- **MM6608**: *Influenza Vaccine Payment Allowances - Annual Update for 2009-2010 Season* at **http://www.cms.gov/MLNMattersArticles/downloads/MM6608.pdf** on the CMS web site.

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

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

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

- **MM7234**: *New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines* at **http://www.cms.gov/MLNMattersArticles/downloads/MM7234.pdf** on the CMS web site.

2. MLN Seasonal Influenza Related Products for Health Care Professionals

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

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

- *The Medicare Preventive Services Series Part 1 Web-Based Training Course (WBT)* - This WBT contains lessons Medicare-covered preventive vaccinations, including the seasonal influenza vaccine. To take the course, visit the Medicare Preventive Services Educational Products page at **http://www.cms.gov/MLNProducts/35_PreventiveServices.asp** on the internet. Scroll down to “Related Links Inside CMS” and choose “Web-Based Training (WBT) Modules”.

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

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

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

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

4. **Other Resources**

   The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2009 - 2010 flu season:
   - **Advisory Committee on Immunization Practices** are at **http://www.cdc.gov/vaccines/recs/acip/default.htm** on the Internet.
   - **American Lung Association's Influenza (Flu) Center** is at **http://www.lungusa.org** on the Internet. This web site provides a flu clinic locator at http://www.flucliniclocator.org on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
   - **Other sites with helpful information include:**
     - **Centers for Disease Control and Prevention** - **http://www.cdc.gov/flu**;
     - **Flu.gov** - **http://www.flu.gov**;
     - **Food and Drug Administration** - **http://www.fda.gov**;
     - **Immunization Action Coalition** - **http://www.immunize.org**;
     - **Indian Health Services** - **http://www.ihs.gov/**;
     - **National Alliance for Hispanic Health** - **http://www.hispanichealth.org**;
     - **National Foundation For Infectious Diseases** - **http://www.nfid.org/influenza**;
     - **National Library of Medicine and NIH Medline Plus** - **http://www.nlm.nih.gov/medlineplus/immunization.html**;
     - **National Network for Immunization Information** - **http:/www.immunizationinfo.org**;
     - **National Vaccine Program** - **http://www.hhs.gov/nvpo**;
     - **Office of Disease Prevention and Promotion** - **http://odphp.osophs.dhhs.gov**;
     - **Partnership for Prevention** - **http://www.prevent.org**; and
     - **World Health Organization** - **http://www.who.int/en** on the Internet.

Beneficiary Information

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

1 Flu.gov. 2010. About the Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2010 [cited 16 August 2010]. Available from the World Wide Web: **http://www.flu.gov/individualfamily/about/index.html**

2010 Durable Medical Equipment Prosthetics, Orthotics, and Supply (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List (MM7110) (GEN)

MLN Matters® Number: MM7110
Related CR Release Date: September 17, 2010
Related CR Transmittal #: R2056CP

Related Change Request (CR) #: 7110
Effective Date: December 22, 2010
Implementation Date: December 22, 2010

Provider Types Affected
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 are affected.

Provider Action Needed
This article is informational and based on Change Request (CR) 7110 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 2010 Jurisdiction List is an Excel® spreadsheet and is available at **http://www.cms.gov/center/dme.asp** on the Centers for Medicare &.Medicaid Services (CMS) web site.

Additional Information
To see the official instruction (CR7110) issued to your Medicare DME MAC, carrier, or A/B MAC, visit **http://www.cms.gov/Transmittals/downloads/R2056CP.pdf** on the CMS web site. The 2010 Jurisdiction List is attached to CR 7110.

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

Additional Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM7073) (GEN)

MLN Matters® Number: MM7073
Related CR Release Date: November 12, 2010
Related CR Transmittal #: R808OTN

Related Change Request (CR) #: 7073
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7073. The Centers for Medicare & Medicaid Services (CMS) is issuing CR7073 to provide further guidance to suppliers of DMEPOS, regarding licensing, accreditation, or other mandatory quality requirements that may apply. DMEPOS suppliers should be aware that if they are not identified by the National Supplier Clearing House-Medicare Administrative Contractor (NSC-MAC) as **being accredited** to supply the specific product/service AND they are not exempt from accreditation, their claims will be denied automatically by Medicare.

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

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

Section 154(b) of the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) added a new subparagraph (F) to Section 1834(a)(20) of the Act. In implementing quality standards under this paragraph the Secretary will require suppliers furnishing items and services directly, or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009, accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

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

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

- Orthotists;
- Prosthetists;
- Opticians; and
- Audiologists, and
- Pharmacies (. that have an NSC-MAC approved "Attestation for Exemption from Accreditation for a Medicare Enrolled Pharmacy. (see the NSC-MAC web site at Palmettogba.com or the CMS web site) (In accordance with Section 3109(a) of the *Patent Protection and Affordable Care Act*.)

Key Points
All supplier types (except those listed above) who furnish items and services requiring accreditation, directly or as a subcontractor for another entity, must have submitted evidence of accreditation by an accreditation organization designated by the Secretary on or after October 1, 2009.

Edits for the Healthcare Common Procedure Coding System (HCPCS) codes in the product categories designated by MIPPA as requiring accreditation will be in effect. Effective for claims with dates of service on or after July 5, 2011, this Medicare systems edit will automatically deny claims for these codes unless:

1. The DMEPOS supplier has been identified as accredited for the timeframe that covers the date of service on the claim; or
2. The DMEPOS supplier is currently exempt from meeting the accreditation requirements.

When claims are denied, DME MACs will use the following messages:

- Remark Code N211 - "Alert: You may not appeal this decision" and
- Claim Adjustment Reason Code B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

Note: *Products and services requiring accreditation found on CMS 855S, Section 2D next to the NSC-MAC product codes along with HCPCS codes may be found in Attachment B in CR 7073. Their corresponding HCPCS codes may be found in Attachment C. The web address of CR 7073 can be found in the next section of this article.*

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

The official instruction (CR7073) issued to your Medicare DME MAC is available at **http://www.cms.gov/Transmittals/downloads/R808OTN.pdf** on the CMS web site.

To review the CR6566, the initial article listing HCPCS codes, you may go to **http://www.cms.gov/MLNMattersArticles/downloads/MM6566.pdf** on the CMS web site.

For additional information about the NSC-MAC and Recent Regulatory Revisions Pertinent to Suppliers of DMEPOS MM6282 is available at **http://www.cms.gov/mlnmattersarticles/downloads/MM6282.pdf** on the CMS web site.

Durable Medical Equipment (DME) National Competitive Bidding (NCB) Implementation- Phase 11E: Remittance Advice (RA) and Medicare Summary Notice (MSN) Messages for Round One (MM7066) (GEN)

MLN Matters® Number: MM7066
Related CR Release Date: September 24, 2010
Related CR Transmittal #: R777OTN
Related Change Request (CR) #: 7066
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected
Providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries who reside in Competitive Bidding Areas (CBAs).

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7066 to alert providers that Medicare contractors are required to use the appropriate remark, reason and Medicare Summary Notice (MSN) messages when processing National Competitive Bidding (NCB) claims for the Round One Rebid, as noted in the *Key Points* section below. Make certain your billing staffs are aware of these changes.

Background
Round One of the DMEPOS Competitive Bidding Program was implemented on July 1, 2008, in 10 competitive bidding areas, as mandated by the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA). As part of the *Medicare Improvements for Patients and Providers Act of 2008* (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 re-compete the contracts in 2009. MIPPA also excluded certain DMEPOS items and areas from competitive bidding and provided an exemption to the program for hospitals that furnish certain types of DMEPOS items to their own patients.

On January 16, 2009, CMS issued an interim final regulation with comment period that incorporates changes required by the MIPPA. This rule implements certain MIPPA provisions that delay implementation of Round One of the Competitive Bidding Program and

required CMS to conduct a second Round One competition (the Round One rebid) in 2009 and mandated certain changes for both the Round One rebid and subsequent rounds of the program. CR 7066 instructs Medicare contractors to use specific Medicare Summary Notices (MSN), which go to beneficiaries, and Remittance Advice (RA) messages for providers/suppliers for specific circumstances when processing NCB claims. Those RA messages are the subject of this article.

Key Points of CR 7066
The following points detail the messages that providers and suppliers may receive as a result of the DME NCB implementation as discussed in CR 7066:

1. **On remittance advices on claims paid for beneficiaries residing in CBA and obtaining an item from contract supplier in their CBA, you will receive the following, as appropriate:**
    - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

2. **When denying a claim for a beneficiary who resides in a CBA who obtains an item from a non-contract supplier that has not obtained a signed Advance Beneficiary Notice (ABN), you will receive the following:**
    - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - 96 - Non-covered charge(s).
    - N211 - Alert: You may not appeal this decision.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

3. **When a supplier has collected more than the 20 percent co-pay and any remaining deductible for an NCB claim, you will receive the following:**
    - MA59 - Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
    - N211 - Alert: You may not appeal this decision.

4. **When a claim is denied for an NCB item obtained from a non-contract supplier when the supplier has obtained an ABN, the following messages are used:**
    - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - 96 - Non-covered charge(s).
    - N211 - Alert: You may not appeal this decision.
    - M38 - The patient is liable for the charges for this item/service. The patient was informed in writing before the service was furnished that CMS would not pay for the item/service, and the patient agreed to pay by signing the Advanced Beneficiary Notice (ABN).

5. **When a beneficiary from a CBA travels to a different CBA and obtains an NCB item from a contract supplier in that CBA, the following messages are returned for the paid claim:**
    - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.

- M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project For more information regarding this project, contact your local contractor.
- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

6. **When a beneficiary from a CBA travels to an area that is not designated as a CBA, the following messages accompany the paid claim:**
   - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
   - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

7. **When Medicare makes payment to a non-contract supplier at the bid price on a grandfathered claim, the following messages are used:**
   - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
   - M113 - Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.
   - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

8. **The following messages are used when payment is made to a non-contract supplier at the fee schedule amount on a grandfathered claim for inexpensive and routinely purchased (IRP) items or capped rental base equipment:**
   - M113 - Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.
   - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

9. **When claims from physicians or hospitals acting as DMEPOS suppliers and there is no matching office visit found in Medicare claims history, the claims are denied using the following:**
   - B15 - Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
   - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
   - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

10. **When beneficiary-submitted claims that are subject to NCB are denied, the following messages are used:**
    - 111 - Not covered unless the provider accepts assignment.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.

- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- N211 - Alert: You may not appeal this decision.

11. Paper claims subject to NCB are denied using the following messages:

- A1 - Claim/Service Denied.
- M117 - Not covered unless submitted via electronic claim.
- M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- N211 - Alert: You may not appeal this decision.

12. Medicare will deny claims from Skilled Nursing Facilities (SNF) when the SNF acts as a limited contract supplier, but the place of service does not indicate a SNF. In denying such claims, the following messages are used:

- 170 - Payment is denied when performed/billed by this type of provider.
- M77 - Missing/incomplete/invalid place of service.
- M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

13. The following messages are used by Medicare when making payments for oxygen in situations where the beneficiary does not use a grandfathered supplier, so that when the 36-month payment cap under the *Deficit Reduction Act* (DRA) has been reached, the cap must be increased for a total of up to 45 payments:

- M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

14. The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for oxygen equipment when the payment cap has been reached:

- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- N211 - Alert: You may not appeal this decision.
- N370 - Billing exceeds the rental months covered/approved by the payer.
- M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.

15. The following messages are used by Medicare when making payments for capped rental situations where the beneficiary does not use a grandfathered supplier, so that a total maximum of up to 25 payments will be made:

- M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

16. **The following message is used when Medicare returns unassigned NCB claims as unprocessable:**
    - 111 - Not covered unless the provider accepts assignment.

17. **The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for a capped rental item when the payment cap has been reached :**
    - B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N370: Billing exceeds the rental months covered/approved by the payer.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

18. **Medicare uses the following messages to deny claims when a modifier required for NCB is missing from a claim line:**
    - 4 - The procedure code is inconsistent with the modifier use or a required modifier is missing.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

19. **Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for both the base oxygen equipment and the related oxygen contents received from a non-contract supplier when the rental period for the base oxygen equipment began on or after the start date of the Round One Rebid:**
    - 96 - Non-covered charge(s).
    - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - N211 - Alert: You may not appeal this decision.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

20. **Medicare uses the following messages when denying oxygen content claims from a non-contract supplier that is not the same non-contract supplier that received the 36th month base oxygen equipment rental payment, when the initial date on the Certificate of Medical Necessity (CMN) for the base oxygen equipment is prior to the start date of the Round One Rebid and the CBA-residing beneficiary is not traveling:**
    - B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N211 - Alert: You may not appeal this decision.
    - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

21. **Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for portable oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the stationary oxygen equipment prior to the start of the National Competitive Bid Round One Rebid (the stationary oxygen equipment is not a grandfathered item):**
    - 96 - Non-covered charge(s).
    - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

- M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- N211 - Alert: You may not appeal this decision.
- MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

22. **Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for stationary oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the portable oxygen equipment prior to the start of the National Competitive Bid Round One Rebid (the portable oxygen equipment is not a grandfathered item):**
    - 96 - Non-covered charge(s).
    - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - N211 - Alert: You may not appeal this decision.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

23. **Medicare uses the following messages when denying claims for replacement of an item that is subject to the DMEPOS Competitive Bidding Program when submitted by non-contract suppliers, even when submitted with the "RA" modifier:**
    - 96 - Non-covered charge(s).
    - M115 - This item is denied when provided to the patient by a non-contract or non-demonstration supplier.
    - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - N211 - Alert: You may not appeal this decision.
    - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

Note: *For all the above situations, Medicare contractors assign a Group Code of "CO" - Contractual Obligation.*

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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

The official instruction associated with this CR7066 issued to your Medicare DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R777OTN.pdf** on the CMS web site.

To review the CMS DME web site that provides a complete listing of links to DME related information you may go to **http://www.cms.gov/center/dme.asp** on the CMS web site.

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

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

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

To review Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception you may go to **http://www.cms.gov/MLNMattersArticles/downloads/MM6677.pdf** on the CMS web site.

Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696) (SE1011) (GEN)

MLN Matters Number: SE1011 - Revised
Related CR Release Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, and R328PI
Related Change Request (CR) #: 6421, 6417, and 6696
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on November 26, 2010 to include the following statement: The Centers for Medicare & Medicaid Services (CMS) previously announced that, beginning January 3, 2011, if certain Part B billed items and services require an ordering/referring provider and the ordering/referring provider is not in the claim, is not of a profession that is permitted to order/refer, or does not have an enrollment record in the Medicare Provider Enrollment, Chain and Ownership System (PECOS), the claim will not be paid. The automated edits will not be turned on effective January 3, 2011. We are working diligently to resolve enrollment backlogs and other system issues and will provide ample advanced notice to the provider and beneficiary communities before we begin any automatic nonpayment actions.*

Provider Types Affected
Physicians, non-physician practitioners (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider Action Needed
If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855I). If you reassign your Medicare benefits to a group or clinic, you will also need to complete the CMS-855R.

What Providers Need to Know
Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: Beginning January 3, 2011 **(See statement on page one delaying implementation of phase 2.)**, Medicare will reject Part B claims that fail the Ordering/Referring Provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment records in PECOS and must be of a specialty that is eligible to order and refer.

Enrolled physicians and non-physician practitioners who do not have enrollment records in PECOS and who submit enrollment applications in order to get their enrollment information into PECOS should not experience any disruption in Medicare payments, as a result of submitting enrollment applications.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the web, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the Ordering/Referring Provider edits, which is January 3, 2011.

Background
The Centers for Medicare & Medicaid Services (CMS) has implemented edits on Ordering and Referring Providers when they are required to be identified in Part B claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

- Below are examples of some of these types of claims:
  - Claims from laboratories for ordered tests;
  - Claims from imaging centers for ordered imaging procedures;
  - Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS; and
  - Claims from specialists or specialty groups for referred services.
- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:
  - Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, doctor of chiropractic medicine),
  - Physician Assistant,
  - Certified Clinical Nurse Specialist,
  - Nurse Practitioner,
  - Clinical Psychologist,
  - Certified Nurse Midwife, and
  - Clinical Social Worker.

Questions and Answers Relating to the Edits
1. What will the edits do?
The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e., the enrollment record is in PECOS and it contains the National Provider Identifier (NPI)), and (2) is of a type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?
These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?
These edits are being implemented in two phases:

- **Phase 1** began on October 5, 2009, and is scheduled to end on January 2, 2011. In Phase 1, if the Ordering/Referring Provider does not pass the edits, the claim will be processed and paid (assuming there are no other problems with the claim) but the Billing Provider (the provider who furnished the item or service that was ordered or referred) will receive an informational message* from Medicare in the Remittance Advice†.

  The informational message will indicate that the identification of the Ordering/Referring provider is missing, incomplete, or invalid, or that the Ordering/Referring Provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication.

  Note: *if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.*

- **Phase 2** is scheduled to begin on January 3, 2011, and will continue thereafter. In Phase 2, if the Ordering/Referring Provider does not pass the edits, the claim will be rejected. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.‡

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment web site, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a periodic basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report, and to download it, go to **http://www.cms.gov/MedicareProviderSupEnroll**; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

Effect of Edits on Providers

A. I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the Billing Provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, **you-the Ordering/Referring Provider-need to ensure that:**

1. **You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).**
   - If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in 6 or more years, you do not have an enrollment record in PECOS. **You need to take action to establish one. See the last bullet in this section.**
   - If you are not sure, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
   - **If you do not have an enrollment record in PECOS:**
     - You need to submit an enrollment application to Medicare in one of two ways:
       a. **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the Certification Statement and mail the Certification Statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to **http://www.cms.gov/MedicareProviderSupEnroll**, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

NOTE for physicians/non-physician practitioners who reassign all their Medicare benefits to a group/clinic: If you reassign all of your Medicare benefits to a group/clinic, the group/clinic must have an enrollment record in PECOS in order for you to enroll via the web. You should check with the officials of the group/clinic or with your designated Medicare enrollment contractor if you are not sure if the group/clinic has an enrollment record in PECOS. If the group/clinic does not have an enrollment record in PECOS, you will not be able to use the web to submit your enrollment application to Medicare. You will need to submit a paper application, as described in the bullet below.

b. **Obtain a paper enrollment application (CMS-855I)**, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you reassign all your Medicare benefits to a group/clinic, you will also need to fill out, sign and date the CMS-855R, obtain the signature/date signed of the group's Authorized Official, and mail the CMS-855R, along with the CMS-855I, to the designated Medicare enrollment contractor. Enrollment applications are available for downloading from the CMS forms page (**http://www.cms.gov/cmsforms**) or by contacting your designated Medicare enrollment contractor.

NOTE about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

2. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.** When you enrolled in Medicare, you indicated your Medicare specialty. **Any** physician specialty and **only** the non-physician practitioner specialties listed above in this Article are eligible to order or refer in the Medicare program.

B. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?

As the Billing Provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the two edits on the Ordering/Referring Provider so that you will not receive informational messages in Phase 1 and so that your claims will be paid in Phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have enrollment records in PECOS that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the Ordering/Referring Provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits. Keep in mind that this Ordering Referring Report will be replaced about once a month to ensure it is as current as practicable. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may resubmit a claim that did not initially pass the Ordering/Referring Provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/Referring Provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, Billing Providers should contact their local carrier, A/B MAC, or DME MAC.

Billing Providers should be aware that claims that are rejected because they failed the Ordering/Referring Provider edits are not denials of payment by Medicare that would expose the Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate.**

Additional Guidance

1. **Orders or referrals by interns or residents.** Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/she may not be identified in a Medicare claim as the Ordering/Referring Provider. The teaching, admitting, or supervising physician is considered the Ordering/Referring Provider when interns and residents order and refer, and that physician's name and NPI would be reported on the claim as the Ordering/Referring Provider.

2. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare.** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

3. **Orders or referrals by dentists.** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review the following related CRs:

- CR 6417 at **http://www.cms.gov/Transmittals/downloads/R642OTN.pdf** on the CMS web site;
- CR 6421 at **http://www.cms.gov/Transmittals/downloads/R643OTN.pdf** on the CMS web site; and
- CR 6696 at **http://www.cms.gov/Transmittals/downloads/R328PI.pdf** on the CMS web site.

If you have questions, please contact your Medicare carrier, Part A/B Medicare Administrative Contractor (A/B MAC), or durable medical equipment Medicare Administrative Contractor (DME/MAC), at their toll-free numbers, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

*	The informational messages vary depending on the claims processing system.
†	DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.
‡	NPIs were added only when the matching criteria verified the NPI.

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.

End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services (MM7064) (GEN)

MLN Matters® Number: MM7064 - Revised
Related CR Release Date: November 17, 2010
Related CR Transmittal #: R2094CP

Related Change Request (CR) #: 7064
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: *This article was revised on November 18, 2010, to reflect the revised CR 7064 that was issued on November 17, 2010. CR 7064 was revised to reflect a revised ESRD Pricer layout, the deletion of several drugs, the identification of drugs that may be eligible for the ESRD outlier payment, to provide an additional list of laboratory tests that comprise the AMCC and to delete several laboratory tests. There were no changes in policy. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7064 were revised. All other information is the same.*

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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 7064 which announces the implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011.

What You Need to Know
Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital-based providers of services and renal dialysis facilities, that will cover all the resources used in providing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis in the ESRD facility or at a patient's home, drugs, biologicals, laboratory tests, training, and support services. The ESRD PPS provides ESRD facilities a 4-year phase-in (transition) period under which they would receive a blend of the current payment methodology and the new ESRD PPS payment. In 2014, the payments will be based 100 percent on the ESRD PPS payment.

What You Need to Do
Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the Background and Additional Information Sections of this article for further details regarding the ESRD PPS.

Background
The *Medicare Improvements for Patients and Providers Act* (MIPPA); Section 153(b); see **http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331** on the Internet) requires the Centers for Medicare & Medicaid services (CMS) to implement an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective January 1, 2011. Once implemented, the ESRD PPS will replace the current basic case-mix adjusted composite payment system and the methodologies for the reimbursement of separately billable outpatient ESRD related items and services.

Specifically, the ESRD PPS combines payments for composite rate and separately billable services into a single base rate. The per dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in:

- Wage levels among the areas in which ESRD facilities are located;
- Patient-level adjustments for case-mix;
- An outlier adjustment (if applicable);
- Facility-level adjustments;
- A training add-on (if applicable); and
- A budget neutrality adjustment during the transition period through 2013.

Patient-level Adjustments
The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier Adjustment
ESRD facilities that are treating patients with unusually high resource requirements, as measured through their utilization of identified services beyond a specified threshold, will be entitled to outlier payments. Such payments are an additional payment beyond the otherwise applicable case-mix adjusted prospective payment amount.

ESRD outlier services are the following items and services that are included in the ESRD PPS bundle:

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: *Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.*

Facility-level Adjustments
The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed from Core Based Statistical Areas (CBSAs). The facility-level adjustments also include an adjuster for facilities treating a low-volume of dialysis treatments.

Training Add-On
Facilities that are certified to furnish training services will receive a **training add-on payment amount of $33.44**, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. The training add-on applies to both peritoneal dialysis (PD) and hemodialysis (HD) training treatments.

Adjustments Specific to Pediatric Patients
The pediatric model incorporates separate adjusters based on two age groups (<13, 13-17) and dialysis modality (hemodialysis, peritoneal dialysis). The per-treatment base rate as it applies to pediatric patients is the same base rate that applies for adult patients, which is also adjusted by the area wage index. However, due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted by the same patient-level case-mix adjusters as for adult patients. Instead, the pediatric payment adjusters reflect the higher total payments for pediatric composite rate and separately billable services, compared to that of adult patients.

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

Note: *Pediatric dialysis treatments are not eligible for the low-volume adjustment.*

ESRD PPS 4-year Phase-in (Transition) Period
The ESRD PPS provides ESRD facilities with a 4-year transition period under which they would receive a blend of payments under the prior case-mix adjusted composite payment system and the new ESRD PPS as noted in the following table:

The ESRD PPS 4-year Transition Period Blended Rate Determination

Calendar Year	Blended Rate
2011	75 percent of the old payment methodology, and 25 percent of new PPS payment
2012	50 percent of the old payment methodology, and 50 percent of the new PPS payment
2013	25 percent of the old payment methodology, and 75 percent of the new PPS payment
2014	100 percent of the PPS payment

For Calendar Year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

The **ESRD PPS base rate is $229.63**, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.53711.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

Once the payment rate for the dialysis treatment is determined, the last item in the computation to determine the final payment rate is the application of the transition budget neutrality factor of .969, that is, a 3.1 percent reduction.

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

Note: *Providers wishing to opt out of the transition period blended rate must notify their Medicare Contractor on or before November 1, 2010. Providers shall not submit claims spanning date of service in 2010 and 2011.*

Three New Adjustments Applicable to the Adult Rate

1. **Comorbid Adjustments:** The new ESRD PPS provides for **3 categories of chronic comorbid conditions and 3 categories for acute comorbid conditions**. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. **The 3 chronic comorbid categories** eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia;
   - Monoclonal gammopathy (in the absence of multiple myeloma); and
   - Myelodysplastic syndrome.

   The **3 acute comorbid categories** eligible for a payment adjustment are:
   - Bacterial Pneumonia;
   - Gastrointestinal Bleeding; and
   - Pericarditis.

2. **Onset of Dialysis Adjustment:** An adjustment will be made for patients that have Medicare ESRD coverage during their first 4 months of dialysis. This adjustment will be determined by the dialysis start date in Medicare's Common Working File as provided on the CMS Form 2728, completed by the provider. When the onset of dialysis adjustment is provided, the claim is not entitled to a comorbid adjustment or a training adjustment.

3. **Low-Volume Facility Adjustment:** Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three (3) years preceding the payment year. The 3 years preceding treatment data should be reflected on the last 2 settled cost reports and the most recent must be filed. The provider must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment.

Change in Processing Home Dialysis Claims

For claims with dates of service on or after January 1, 2011, the payment of home dialysis items and services furnished under Method II, regardless of home treatment modality, are included in the ESRD PPS payment rate.

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility and
- Will be processed as Method I claims.

Note: *CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.*

Consolidated Billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Other Billing Reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.

- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.

- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.

- When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign Group code CO.

- All 72X claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.

- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.

- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.

- Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional Information
The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2094CP.pdf** on the CMS web site. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services;
- Attachment 4, which is a list of DME ESRD Supply HCPCS codes used in for ESRD PPS consolidated billing edits;
- Attachment 5, which contains a list of DME ESRD Supply HCPCS codes that are NOT payable to DME suppliers;
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing;
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing; and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

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

Implementation of Errata version 5010 of Health Insurance Portability and Accountability Act (HIPAA) transactions, and updates in 837I, 837P, and 835 flat files (MM7202) (GEN)

MLN Matters® Number: MM7202
Related CR Release Date: November 10, 2010
Related CR Transmittal #: R2090CP
Related Change Request (CR) #:7202
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected
This article is for physicians, providers and suppliers who bill Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment DME) MACs, and Regional Home Health Intermediaries (RHHI)), for services provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7202 to alert and update providers about the Administrative Simplification provisions of HIPAA Regulations that the Secretary of the Department of Health and Human Services (DHHS) is required to adopt regarding standard electronic transactions and code sets. Currently, CMS is in the process of implementing an ERRATA version of 5010 of the HIPAA transactions as well as the updates to the 837I, 837P and 835 flat files. **Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.**

Background
The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective Date of the regulation: March 17, 2009;
- Level I compliance by December 31, 2010;
- Level II Compliance by December 31, 2011; and
- All covered entities have to be fully compliant on January 1, 2012

To review the explanation of these levels you may go to an earlier *MLN Matters*® article, MM6975 on the *Additional Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)* at
http://www.cms.gov/MLNMattersArticles/downloads/MM6975.pdf on the CMS web site.

Key Points of CR7202
CMS is working with your Medicare contractors to implement the new HIPAA standard (version 5010) correctly and:

- CMS expects that external testing will start on January 2011, but no sender/receiver will be migrated to 5010A1 production before April 2011;
- During the transition period January 2011 - March, 2011, Medicare contractors will be ready to receive/send transactions in version 4010A1 as well as test in version 5010. From April 2011 to December 2011, contractors will be ready to receive/send transactions in version 4010A1 as well as test and receive/send all transactions in version 5010 or the appropriate errata versions; and
- All Medicare claims processing systems will use appropriate X12 based Flat File layouts for transactions 837I, 837P, and 835, as attached to CR7202. (To review the file descriptions, go to **http://www.cms.gov/Transmittals/downloads/R2090CP.pdf** on the CMS web site.)
- Over the past year, there has been discussion about modifications needed to implement 5010 correctly. As a result, X12N released the ERRATA modifications, and they were adopted by DHHS. CMS will implement the changes that impact Medicare and update the relevant flat files even if specific modifications do not impact Medicare.
- The ERRATA are basically modifications to some of the TR3s. For Medicare the following TR3 name changes will be required per:
    - 005010X279A1 270/271 Health Care Eligibility Benefit Inquiry and Response (A separate CR will be issued for the 270/271);
    - 005010X221A1 835 Health Care Claim Payment/Advice;
    - 005010X222A1 837 Health Care Claim: Professional;
    - 005010X223A2 837 Health Care Claim: Institutional; and
    - 005010X231A1 999 Implementation Acknowledgment for Health Care Insurance.

Additional Information
The official instruction, CR 7202 issued to your carrier, A/B MAC, and RHHI regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2090CP.pdf** on the CMS web site.

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

Important News about Flu Shot Frequency for Medicare Beneficiaries (SE1026) (GEN)

MLN Matters Number: SE1026
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
This article is for physicians, providers, and suppliers providing flu shot services to Medicare beneficiaries.

What You Need to Know
This article provides important information to physicians and other providers regarding the frequency of allowable flu vaccinations for Medicare beneficiaries.

Background
Effective for services furnished on or after May 1, 1993, the Medicare Part B program covers influenza virus vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity enrolled in the Medicare program. Typically, one vaccine is allowable per influenza virus season (once a year in the fall or winter). Medicare will pay for more than one influenza virus vaccination per influenza season if a physician determines and documents in the patient's medical record that the additional vaccination is reasonable and medically necessary. Medicare beneficiaries may receive the vaccine once each influenza season, paid by Medicare, without a physician's order and without the supervision of a physician. A patient could receive an

influenza virus vaccine ***twice*** in a calendar year and Medicare will pay for both. For example, a beneficiary may receive an influenza virus vaccination in January 2010 and another influenza virus vaccination in November 2010.

Medicare Billing for Flu Vaccines
Because Medicare beneficiaries generally fall into a high-risk category, they are being encouraged to obtain the flu vaccine every flu season. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, for Medicare payment of the vaccine and its administration, beneficiaries should obtain their vaccinations from a Medicare-enrolled physician/provider.

If you are a Medicare-enrolled physician or provider (including centralized billers) and have the flu vaccine available, you must bill Medicare for the cost of the vaccination and its administration. Medicare beneficiaries do not pay any deductible or coinsurance. Please remember that Medicare allows for roster billing when you administer the flu vaccine to a number of beneficiaries at one location (e.g., a physician's office).

Additional Information
The specific rules to follow for roster billing can be found in Chapter 18, Section 10.3 of the *Medicare Claims Processing Manual* at **http://www.cms.gov/manuals/downloads/clm104c18.pdf** on the Centers for Medicare & Medicaid Services (CMS) web site.

If you do not have the vaccine available, you should refer your patients to 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048) or to **http://www.medicare.gov** where they can get the phone number for their state health department. Health departments throughout the United States are attempting to ensure that as many high-risk individuals as possible will get a flu vaccine.

Instructions for PLB code reporting on Remittance Advice, a Crosswalk between the HIGLAS PLB codes and ASC X12 Transaction 835 PLB codes, and RAC Recoupment Reporting on Remittance Advice for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims (MM7068) (GEN)

MLN Matters® Number: MM7068
Related CR Release Date: November 12, 2010
Related CR Transmittal #: R812OTN

Related Change Request (CR) #:7068
Effective Date: April 1, 2011
Implementation Date: April 4, 2011; July 5, 2011 for Institutional providers and DME Suppliers

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

Provider Action Needed
Change Request (CR) 7068 provides instructions to Medicare Carriers, MACs, FIs, and RHHIs about using and reporting PLB codes on the Remittance Advice (RA). It also includes instruction for DME MACs for reporting RAC recoupment when there is a time difference between the creation of the Accounts Receivable and actual recoupment of money.

The attachment in CR 7068 provides a list of PLB codes to be reported on the 835 as well as the paper remittance advice and a crosswalk between the HIGLAS PLB codes and the ASC X12 Transaction 835 PLB codes to ensure that PLB code reporting on the RA is consistent and uniform across the board.

Background
In the *Tax Relief and Health Care Act of 2006*, Congress required a permanent and national Recovery Audit Contractors (RAC) program to be in place by January 1, 2010. The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and can go back 3 years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.

Section 935 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) (Publication. L.108-173) which amended Title XVIII of the *Social Security Act* (the Act) has added a new paragraph (f) to §1893 of the Act, the Medicare Integrity Program. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment under the provisions of Section 935 of the MMA can begin no earlier than the 41st day (see CR6183 - Transmittal 141, issued September 12, 2008), and can happen only when a valid request for a redetermination has not been received within that period of time.

Under the scenario just described, the RA has to report the actual recoupment in two steps:

Step I: Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here)
Step II: Report the actual recoupment.

In a previous CR (Transmittal 659, CR6870), Medicare Carriers, FIs and A/B MACs were instructed to provide enough detail in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 - Claim Overpayment Recovery - in ASC X12N/005010X221 provides a step-by-step process, regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done. CR7068 instructs DME MACs how to report on the RA when an overpayment is identified and also when Medicare actually recoups the overpayment in a future RA.

RAC Recoupment Reporting - DME Claims Only

Step I: **Claim Level:**

The original claim payment is taken back and the new payment is established (Reversal and Correction).

Provider Level:

PLB03-1 - PLB reason code FB (Forward Balance)
PLB 03-2 shows the detail:
PLB-03-2
1-2: 00
3-19: Adjustment CCN#
20-30: HIC#
PLB04 shows the adjustment amount to offset the net adjustment amount shown at the service level. If the service level net adjustment amount is positive, the PLB amount would be negative and vice versa.

Step II: **Claim Level:**

No additional information at this step

Provider Level:

PLB03-1 - PLB reason code WO (Overpayment Recovery)
PLB 03-2 shows the detail:
PLB-03-2
1-2: 00
3-19: Adjustment CCN#
20-30: HIC#
PLB04 shows the actual amount being recouped

A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created - **Step I**. This document contains a control number for tracking purpose that is also reported on the RA.

CMS has decided to follow the same reporting protocol for all other recoupments in addition to the 935 RAC recoupment mentioned above.

Note: *CR 7068 instructions, regarding recoupment, apply to both 004010A1 and 005010 versions of ASC X12 Transaction 835 and Standard Paper Remittance (SPR). In some very special cases the HIC # may have to be truncated to be compliant with the 004010A1 Implementation Guide.*

PLB Code Reporting
The RA reports payments and adjustments to payments at 3 levels: a) service, b) claim, and c) provider.

The adjustments at the service and the claim level are reported using 3 sets of codes:

- Group Codes,
- Claim Adjustment Reason Codes (CARCs), and
- Remittance Advice Remark Codes (RARCs).

Provider level adjustments are reported using the PLB codes. The PLB code list is an internal code list that can be changed only when there is a change in the version.

In Version 004010A1, the following PLB codes are available for use: 50, 51, 72, 90, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, AND ZZ. In version 005010, two new codes - AH and HM - have been added, and code ZZ has been deleted. The other change in Version 005010 is the way situational field PLB03-2 for reference identification is used.

Field	Version 00401A1	Version 005010
PLB03-1		AH - additional code HM - additional code ZZ - deleted code
PLB03-2	**Max:** 30 **Position 1-2:** Medicare intermediaries must enter the applicable Medicare code **Position 3-19:** Financial control number or the provider level adjustment number or other pertinent identifier **Position 20-30:** Health Insurance Claim (HIC) Number	Max: 50 Required when a control, account or tracking number applies to this adjustment as reported in field PLB03-1 No Medicare specific codes.

HIGLAS uses additional PLB codes from the X12 Standard that are not in the Implementation Guide (IG) or Technical Report (TR) 3. **Medicare must use only those codes that are included in the IG/TR3 to report on the 835.**

HIGLAS PLB Codes and ASC X12 Crosswalk
Currently CMS is transitioning to HIGLAS, and some contractors are still not under HIGLAS. CR 7068 applies to both HIGLAS and Non-HIGLAS contractors with the goal of uniform and consistent reporting on the 835 across the board. Secondly, CMS is also in the process of implementing version 005010/005010A1. Attachment - 835 PLB Code Mapping is applicable to Version 004010A1 as well as 005010A1.

The PLB codes to report on the 835 and HIGLAS and HIPAA PLB Crosswalk may be found in the attachment in CR 7068

Additional Information
For complete details regarding this Change Request (CR) please see the official instruction (Transmittal 812/CR 7068) issued to your Medicare contractor at **http://www.cms.gov/transmittals/downloads/R812OTN.pdf** on the CMS web site.

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

- Limitation on Recoupment (935) for Provider, Physicians and Suppliers Overpayments at **http://www.cms.gov/MLNMattersArticles/downloads/MM6183.pdf**, and
- Reporting of Recoupment for Overpayment on the Remittance Advice (RA) at **http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf** on the CMS web site.

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

January 2011 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (MM7181) (GEN)

MLN Matters® Number: MM7181
Related CR Release Date: November 5, 2010
Related CR Transmittal #: R2088CP

Related Change Request (CR) #:7181
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7181, which provides the January 2011 quarterly update for the DMEPOS competitive bidding single payment amounts. CR 7181 also provides necessary changes to Healthcare Common Procedure Coding System (HCPCS) codes and ZIP codes for the competitive bidding program. The single payment rates for the Round One Rebid of the DMEPOS competitive bidding program are implemented through CR 7181 and are effective January 1, 2011. Be sure billing staff are aware of these changes.

Background
The Medicare DMEPOS competitive bidding program was mandated by the *Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003*. The program's objectives include:

- Assuring beneficiary access to quality DMEPOS items;
- Reducing the amount Medicare pays for DMEPOS items; and
- Reducing the financial burden on beneficiaries by reducing the coinsurance they pay for DMEPOS items.

The Round One Rebid Competitive Bidding Program will be implemented on January 1, 2011 in Competitive Bidding Areas (CBAs) defined by ZIP codes within nine of the largest Metropolitan Statistical Areas (MSAs). The CBAs in the Round One Rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando-Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBA only, Support Surfaces (Group 2 Mattresses and Overlays). A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor's (CBIC) web site at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf** on the Internet.

Key Points of 7181
Competitive Bidding ZIP Codes
For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA number. The competitive bidding CBA numbers and associated names are as follows:

- 16740 - Charlotte-Gastonia-Concord, NC-SC (non-mail order and mail order)
- 16741 - Charlotte-Gastonia-Concord, NC-SC (mail order only)
- 17140 - Cincinnati-Middletown, OH-KY-IN (non-mail order and mail order)
- 17141 - Cincinnati-Middletown, OH-KY-IN (mail order only)
- 17460 - Cleveland-Elyria-Mentor, OH (non-mail order and mail order)
- 17461 - Cleveland-Elyria-Mentor, OH (mail order only)
- 19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
- 19101 - Dallas-Fort Worth-Arlington, TX (mail order only)

- 28140 - Kansas City, MO-KS (non-mail order and mail order)
- 28141 - Kansas City, MO-KS (mail order only)
- 33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
- 33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
- 36740 - Orlando- Kissimmee, FL (non-mail order and mail order)
- 36741 - Orlando- Kissimmee, FL (mail order only)
- 38300 - Pittsburgh, PA (non-mail order and mail order)
- 38301 - Pittsburgh, PA (mail order only)
- 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order)
- 40141 - Riverside-San Bernardino-Ontario, CA (mail order only)

Public Use Files

The competitive bidding zip codes and single payment amounts per product category and CBA are also available on the Competitive Bidding Implementation Contract (CBIC) web site for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The Competitive Bidding Implementation Contractor (CBIC) web site can be accessed at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf** or by visiting **http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp** on the Centers for Medicare & Medicaid Services (CMS) web site. These files can be used to identify when a specific item furnished to a beneficiary is subject to the DMEPOS competitive bidding program.

HCPCS Code Changes

The following HCPCS codes are changing from "K" codes to "E" codes in the HCPCS file, effective January 1, 2011:

- K0734 is crosswalked to E2622
- K0735 is crosswalked to E2623
- K0736 is crosswalked to E2624
- K0737 is crosswalked to E2625

This change to "E" codes for the aforementioned codes will be reflected in the competitive bidding files and public use files as part of this update.

Instructions for Competitive Bidding Modifiers

HCPCS modifiers were developed to facilitate implementation of various policies that apply to certain competitive bidding items. The HCPCS modifiers used in conjunction with claims for items subject to competitive bidding, along with their corresponding effective dates are:

- KG - DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1; effective 7/1/2007
- KK - DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2: effective 7/1/2007
- KU - DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3; effective 7/1/2007
- KW - DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4: effective 1/1/2008
- KY - DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5; effective 1/1/2008
- KL - DMEPOS Item Delivered via Mail; effective 7/1/2007
- KV - DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is furnished as part of a Professional Service; effective 1/1/2008
- KT - Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Areas and Receives a Competitive Bidding Item; effective 4/1/2008
- J4 - DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is furnished by a Hospital upon Discharge; effective 1/1/2010

The KG, KK, KU, KW, and KY modifiers are modifiers that suppliers must use on claims for beneficiaries residing in CBAs to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories. All suppliers, including grandfathered suppliers, should submit claims for competitive bid items using the aforementioned competitive bidding modifiers. The KG and KK modifiers are treated as pricing modifiers in the Round One Rebid of the competitive bidding program and the KU, KW and KY modifiers are reserved for future program use.

Suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258, and A4259) furnished on or after July 1, 2007 (See the *MLN Matters* article related to CR5641 at

http://www.cms.gov/MLNMattersArticles/downloads/MM5641.pdf on the CMS web site.) Effective January 1, 2009, the KL modifier changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers should use the KL modifiers on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts. Contract suppliers must use the KL modifier on all claims for the diabetic supply codes identified above that are furnished via mail order.

The KV modifier is to be used to identify claims for items subject to the exceptions provided in regulations at 42 CFR 414.404(b) for certain competitive bid items that can be furnished by physicians and other practitioners who are not contract suppliers in a competitive bidding area. **Physicians and treating practitioners who are not contract suppliers** and who furnish walkers and related accessories to beneficiaries residing in a CBA must submit the informational KV modifier with claims for items/HCPCS codes in competitive bidding product category 9 (Walkers and Related Accessories), that are appropriately furnished in accordance with this exception to receive payment for these items at the applicable single payment amount. Physicians and practitioners **located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries residing in a CBA must also affix the KV modifier** to claims submitted for these items.

The **KV modifier should not be used** by contract suppliers for competitive bidding product category 9, Walkers & Related Accessories, when submitting competitive bidding claims for this category.

Suppliers should submit claims with the **KT modifier** for non-mail order DMEPOS competitive bidding items that are furnished to beneficiaries that have traveled outside of the CBA in which they reside. This travel modifier must be affixed to competitive bidding claims submitted by non-contract suppliers for traveling beneficiaries residing in CBAs and by contract suppliers in CBAs that are different from the CBA where the traveling beneficiary resides.

Physicians and treating practitioners that are located outside a CBA who furnish walkers and/or related accessories in competitive bidding product category 9 as part of a professional service to traveling beneficiaries must **affix the KT modifier, in addition to the KV modifier**, to claims submitted for these items.

Non-contract Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) that are not located in a CBA should also use the KT modifier on claims for residents with a permanent home address in a CBA. SNF or NF claims that meet the above requirement and are submitted without the KT modifier will be denied.

Claims for mail order competitive bidding diabetic supplies submitted with the KT modifier will be denied. Contract suppliers should submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary's permanent home address.

The J4 modifier is used under the DMEPOS Competitive Bidding Program to denote certain competitively bid items that a hospital can furnish to their patients on the date of discharge without submitting a bid and being awarded a competitive bidding contract. The DME items that a hospital may furnish as part of this exception are limited to: crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. For the Competitive Bidding Program Round One Rebid, the DME competitive bid items that a hospital may furnish as part of this exception are limited to walkers and related accessories. For additional information on this exception, please see (See the *MLN Matters*® article related to CR 6677 at http://www.cms.gov/MLNMattersArticles/downloads/MM6677.pdf on the CMS web site). Hospitals located outside a CBA, who provide walkers and/or related accessories on the date of discharge to traveling beneficiaries residing in a CBA, must also affix the J4 modifier to claims submitted for these items. The J4 modifier should not be used by contract suppliers for the Walkers and Related Accessories competitive bidding product category when submitting competitive bidding claims for this category.

The KE modifier (*Bid Under Round One of the DMEPOS Competitive Bidding Program for Use With Non-Competitive Bid Base Equipment*) was added to the HCPCS file effective January 1, 2009 as a pricing modifier that suppliers must use on all Part B Fee-For-Service claims to identify when the same accessory item can be furnished in multiple DMEPOS Competitive Bidding Program and non-Competitive Bidding Program product categories. For additional information on the use of the KE modifier, please refer to the instructions contained in the *MLN Matters*® article related to CR 6270 at http://www.cms.gov/MLNMattersArticles/downloads/MM6270.pdf on the CMS web site. For beneficiaries residing in competitive bid areas, suppliers should not use the KE modifier to identify competitively bid accessories used with competitively bid base equipment. Rather, such claims should be submitted using the appropriate KG or KK modifier.

The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers are denoted in the single payment amount public use charts found under the supplier page on the CBIC web site:

http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the Internet.

Failure to use or inappropriate use of a competitive bidding modifier on a competitive bidding claim leads to claims denial. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Reminders Regarding the Single Payment Amount
Under the competitive bidding program, single payment amounts replace the current DMEPOS fee schedule payment amounts for competitive bidding items in CBAs. Medicare will pay contract suppliers 80 percent of the single payment amount for each competitively bid item. The beneficiaries will be responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months.

The changes to the power wheelchair payment rules made by section 3136 of the *Affordable Care Act* do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011 or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the single payment amount for the first three months and 75 percent of the single payment amounts paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by the section 3136 of the *Affordable Care Act*, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount. For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.

Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amounts for rented enteral nutrition infusion pumps described by HCPCS code B9000 and B9002, made in accordance with section 40.3 of Chapter 20 of the *Medicare Claims Processing Manual*. That manual information is available at **http://www.cms.gov/Manuals/downloads/clm104c20.pdf** on the CMS web site. The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

Additional Information
The official instruction, CR 7181 issued to your RHHI and DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2088CP.pdf** on the CMS web site.

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

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

Medicare Fee-For-Service Emergency Policies and Procedures: Questions and Answers (Qs & As) for All Types of Emergencies and Disasters - Rescission of CRs 5099, 6146, 6164, 6174, 6209, 6256, 6280, 6284, and 6378 (MM6837) (GEN)

MLN Matters® Number: MM6837
Related CR Release Date: September 21, 2010
Related CR Transmittal #: R772OTN
Related Change Request (CR) #: 6837
Effective Date: November 22, 2010
Implementation Date: November 22, 2010

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

Provider Action Needed
This article is informational only and advises providers on where to find information regarding Medicare policies related to emergency guidance for the duration of the emergency, such as the H1N1 pandemic.

Background
As part of its preparedness efforts for an influenza pandemic, the Centers for Medicare & Medicaid Services (CMS) developed certain emergency guidance and procedures that may be implemented for the Medicare fee-for-service (FFS) program in the event of a pandemic or disaster.

Additional pandemic-specific preparedness guidance and procedures were issued in prior Change Requests (CRs). CR 6837 rescinds the CRs implementing selected influenza pandemic-specific guidance and procedures. Specifically, CR 6837 rescinds CRs 5099, 6146, 6164, 6174, 6209, 6256, 6280, 6284, and 6378.

The guidance and procedures (in the form of Questions & Answers (Qs & As)) previously implemented by the aforementioned CRs will, instead, be made available on the CMS "Emergency" web site at **http://www.cms.gov/Emergency/**, and entitled:

- "Emergency Qs & As - no 1135 waivers required," and
- "Emergency Qs & As - applicable only when an applicable 1135 waiver has been granted."

Additional Information
The official instruction, CR 6837, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R772OTN.pdf** on the CMS web site.

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

Medicare Remit Easy Print (MREP) Enhancement (MM7178) (GEN)

MLN Matters® Number: MM7178
Related CR Release Date: October 8, 2010
Related CR Transmittal #: R2064CP
Related Change Request (CR) #: 7178
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected
This article is for physicians, providers, and suppliers using the MREP Software supplied through Medicare contractors (carriers, Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs) and/or Part A/B Medicare Administrative Contractors (MACs)).

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) announces in CR 7178, the following list of enhancements to the MREP:

- The MREP Demo function has been updated to reflect current functionalities; and
- A report can be run now for Medicare Secondary Payer (MSP) Claims to distinguish the Medicare secondary payments from the primary payments.

If you use the MREP software, be sure to obtain the new version in January and install it to begin benefiting from these enhancements.

Background
CMS developed the free MREP software to enable providers/suppliers to read and print the HIPAA-compliant Electronic Remittance Advice (ERA), also known as Transaction 835. MREP was first implemented in October 2005, and MREP has been enhanced continuously based on requests/comments received from users. These enhancements are based on requests received either through the carriers, MACs, DME MACs or through the CMS MREP web site.

Additional Information
The official instruction, CR 7178 issued to your carrier, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2064CP.pdf** on the CMS web site.

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

Partial Code Freeze Prior to ICD-10 Implementation (SE1033) (GEN)

MLN Matters® Number: SE1033
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
This *MLN Matters*® Special Edition Article affects all Medicare Fee-For-Service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What You Need to Know
At the ICD-9-CM Coordination & Maintenance (C&M) Committee Meeting, held on September 15, 2010, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013.

Considerable interest was expressed in dramatically reducing the number of annual updates to both coding systems. It was suggested that such a reduction in code updates would allow vendors, providers, system maintainers, payers, and educators a better opportunity to prepare for the implementation of ICD-10. Additional public comments on this issue were received prior to this meeting.

The partial freeze will be implemented as follows:
- The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012 there will be only limited code updates to both ICD-9- CM and ICD- 10 code sets to capture new technology and new diseases.
- On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses. There will be no updates to ICD-9 -CM on October 1, 2013 as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

To view the transcript of the meeting, go to: **http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp** on the CMS web site. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_Morning_Transcript' file. This section appears on page 4 of the 78-page document.

To view the Summary Report of the meeting, go to: **http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp** on the CMS web site. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_ICD9_Meeting_Summary_report.pdf' file. Information on the Code Freeze begins on page 5.

Additional Information
CMS has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at **http://www.cms.gov/ICD10** on the CMS web site.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

- **Medicare Fee-for-Service Provider Resources Web Page** - This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark **http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp** and check back regularly for access to ICD-10 implementation information of importance to you. **Note:** *Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.*

- **CMS Sponsored National Provider Conference Calls** - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit **http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage** on the CMS web site.

- **Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at **http://www.cms.gov/ICD10/**, select the **Medicare Fee-for-Service Provider Resources** link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

The following organizations offer providers and others ICD-10 resources:

- **Workgroup for Electronic Data Interchange (WEDI) http://www.wedi.org**; and

- **Health Information and Management Systems Society (HIMSS) http://www.himss.org/icd10** on the Internet.

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

Provider Education for Handling National Provider Identifier (NPI) Issues Related to Deceased Providers Who Had an NPI (MM6984) (GEN)

MLN Matters® Number: MM6984
Related CR Release Date: November 5, 2010
Related CR Transmittal #: R799OTN
Related Change Request (CR) #: 6984
Effective Date: Claims processed on or after April 4, 2011
Implementation Date: April 4, 2011

Provider Types Affected
This article is relevant for claims of physicians, non-physician practitioners, and other providers/suppliers who are deceased and for whom claims are submitted to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Part A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know
This article is based on change request (CR) 6984 and explains how claims should be submitted by representatives of deceased providers who had obtained an NPI prior to death. A claim submitted after May 23, 2007, for a deceased provider who had an NPI will be rejected by Medicare because the provider's NPI was deactivated in the Medicare claims processing system due to the provider's death. **When a deceased provider's claim is rejected by a Medicare contractor because of the absence of an NPI, the claim submitter is expected to contact the Medicare contractor to discuss payment of the claim and the provider's death.**

The Medicare contractor will ask the representative of the provider's estate to submit the claim in paper format and will instruct the representative that Item 19 of the Form CMS-1500 claim must be annotated to state that the provider is deceased.

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

The official instruction, CR6984, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R799OTN.pdf** on the CMS web site.

Results of the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) (SE1030) (GEN)

MLN Matters® Number: SE1030
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
This article is informational only for all physicians, providers, and suppliers billing the Medicare program.

Provider Action Needed
No action is needed. This article is informational only and provides a summary of the findings from the annual MCPSS by the Centers for Medicare & Medicaid Services (CMS) to assess provider satisfaction with service from Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

Background
The MCPSS offers Medicare Fee-For-Service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. The MCPSS elicits information from a sample of hospitals, physicians, Skilled Nursing Facilities (SNFs), home health agencies, clinical laboratories, and other providers and suppliers.

Survey questions focus on seven key business functions of the provider-contractor relationship: provider inquiries, provider outreach & education, claims processing, appeals, provider enrollment, medical review, and provider audit & reimbursement. The 2010 MCPSS survey questions used a new fully labeled rating scale of 1 to 5, "1" representing "very dissatisfied" and "5" representing "very satisfied".

CMS distributed the 2010 survey to approximately 33,000 randomly selected providers, including physicians and other health care practitioners, suppliers, and institutional facilities that serve Medicare beneficiaries across the country. Those health care providers selected to participate in this year's survey were notified in January.

In January 2011, the next MCPSS will be distributed to a new sample of approximately 33,000 Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2011 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Key Points/2010 Results

- Of all providers who responded, more than 69 percent stated they were satisfied or very satisfied with their contractor's overall performance and 13 percent were dissatisfied or very dissatisfied with their contractor's overall performance.
- Audit & Reimbursement and Claims Processing business functions were rated with the highest level of provider satisfaction.
- High satisfaction was also expressed by hospices, End Stage Renal Disease (ESRD) providers, and Rural Health clinics; while low satisfaction was expressed by licensed practitioners and laboratories.
- Individual results were provided to Medicare contractors for their use in process improvement activities.
- CMS is gradually migrating to a fully Web-based survey. The migration to the Web mode of response this year reached an overall total of 65 percent.
- The public report may be found at **http://www.cms.gov/MCPSS/** on the CMS web site.

Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS web site.

For more information about the MCPSS, please visit **http://www.cms.gov/MCPSS/** on the CMS web site.

CMS News Flash (GEN)

Vaccinate Early to Protect Against the Flu. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. Take advantage of each office visit and start protecting your patients as soon as your 2010-2011 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff. **Get Your Flu Vaccine - Not the Flu.** Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit **http://www.cms.gov/AdultImmunizations** on the CMS web site.

Vaccination is the Best Protection Against the Flu. This year, the Centers for Disease Control and Prevention (CDC) is encouraging everyone 6 months of age and older to get vaccinated against the seasonal flu. The risks for complications, hospitalizations and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. And remember, vaccination is particularly important for health care workers, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. **Get Your Flu Vaccine - Not the Flu.** Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza

vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit **http://www.cms.gov/AdultImmunizations** on the CMS web site.

Each Office Visit is an Opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. **Get Your Flu Vaccine - Not the Flu.** Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and **http://www.cms.gov/AdultImmunizations** on the CMS web site.

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program is scheduled to begin in nine competitive bidding areas (CBAs) on January 1, 2011. Referral agents located in CBAs who prescribe DMEPOS for beneficiaries or refer beneficiaries to specific suppliers will need to be aware of which suppliers in the area are contract suppliers as well as other important referring information. Referral agents include such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, and pharmacists who refer beneficiaries for services in a CBA. More information for referral agents can be found in the new Medicare Learning Network® (MLN) fact sheet "The DMEPOS Competitive Bidding Program: Fact Sheet for Referral Agents" located at **http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp** on the CMS web site. This fact sheet is also available to order in hardcopy, free of charge. To order your copy, please visit the MLN homepage at **http://www.cms.gov/mlngeninfo** on the CMS web site.

The Centers for Medicare & Medicaid Services (CMS) has announced the single payment amounts for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The Press Release on this issue is at **http://www.cms.gov/apps/media/press_releases.asp** and a related fact sheet is at **http://www.cms.gov/apps/media/fact_sheets.asp** on the CMS web site.

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The list of contract suppliers is now available at **http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp** on the CMS web site. Visit the CMS web site at **http://www.cms.gov/DMEPOSCompetitiveBid** to view additional information on the Round 1 Rebid.

The Centers for Medicare & Medicaid Services (CMS) has completed the bid evaluation process and announced the single payment amounts for the Round 1 Rebid of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. Competitive bidding will determine where Medicare beneficiaries residing in competitive bidding areas must obtain many DMEPOS items as of January 1, 2011. For additional information about the Medicare DMEPOS Competitive Bidding Program, visit **http://www.cms.gov/DMEPOSCompetitiveBid/** on the CMS web site.

Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013. And in preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards. Make sure your claims continue to get paid. Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you'll have what you need to be ready. A successful transition to ICD-10 will be vital to transforming our nation's health care system. Visit **http://www.cms.gov/ICD10** to find out how The Centers for Medicare & Medicaid Services (CMS) can help prepare you for a smooth transition to Version 5010 and ICD-10.

Remember: ICD-10 Compliance Date for Implementation - October 1, 2013 - Compliance date for implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures) - Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures - it will not be used for physician reporting. There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report CPT and HCPCS codes. For more information about ICD-10 Implementation, please read *MLN Matters*® Special Edition article SE1019 located at **http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf** on the CMS web site.

The Provider Enrollment, Chain and Ownership System (PECOS) is now available for DMEPOS suppliers. DMEPOS suppliers can use Internet-based PECOS to enroll, make a change in their enrollment record, view their Medicare enrollment information on file with Medicare, and check on the status of a Medicare enrollment application via the Internet. For more information about Internet-based PECOS, including contact information for the External User Services (EUS) Help Desk, go to **http://www.cms.gov/MedicareProviderSupEnroll** and select the "Internet-based PECOS" tab on the left side of screen. The EUS Help Desk provides assistance to providers and suppliers if they encounter an application navigation or systems problem with Internet-based PECOS.

As stated in the Centers for Medicare & Medicaid Services (CMS) provider listserv messages that were sent last fall concerning Change Requests (CRs) 6417 and 6421, CMS has made available a file that contains the National Provider Identifier (NPI) and the name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in Medicare's systems that contain an NPI). This file is downloadable by going to the Medicare provider/supplier enrollment web site at **http://www.cms.gov/MedicareProviderSupEnroll** and clicking on "Ordering/Referring Report" on the left-hand side.

The Centers for Medicare & Medicare Services (CMS) has launched the official web site for the Medicare & Medicaid EHR Incentive Programs. This web site provides the most up-to-date, detailed information about the EHR incentive programs, including the latest EHR educational products. The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals and hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. Bookmark this site and visit **http://www.cms.gov/EHRIncentivePrograms** often to learn about who is eligible for the programs, how to register, meaningful use, upcoming EHR training and events, and much more!

The Medicare Learning Network now has Tip Sheets available with important information on the EHR incentive programs. One tip sheet provides user friendly information about incentive payment amounts and describes how they are calculated for fee for service and Medicare Advantage providers. Another provides information on eligibility, timeframes, and maximum payments for the EHR, PQRI, and E-Prescribing program. These Tip Sheets are available at **http://www.cms.gov/EHRIncentivePrograms** on the CMS EHR Incentive Programs web site. Select the Medicare Eligible Professional tab on the left, and then scroll to "Downloads."

All aboard the "DMEPOS Express"... next stop... knowledge!
Visit http://www.medicarenhic.com/dme/dme-eduonline.shtml#podcast
to listen to a selection of the DME MAC A Podcasts.

DME MAC Jurisdiction A Local Coverage Determinations

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

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

Glucose Monitor Supplies - Use of Upgrade Modifiers (SPE)

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it. For glucose monitor supplies, if the quantity of test strips and lancets that is provided exceeds the standard amount specified in the LCD and if the supplier does not have information indicating that all of the criteria for coverage of the excess quantities have been met (i.e., criteria [a]- [f] in the *Glucose Monitors Local Coverage Determination*), that quantity can be considered an upgrade.

General information about the use of upgrade modifiers is found in the *Jurisdiction A Supplier Manual*, Chapter 10. Applying this to test strips and lancets, if a supplier wants to collect from the beneficiary for the excess quantity of supplies, a properly completed ABN must be obtained. If an ABN is obtained, on one claim line the supplier bills the appropriate HCPCS code with a GA modifier and bills the units of service that describe the quantity of supplies that were provided. On the next claim line, the supplier bills the same HCPCS code with a GK modifier and bills the units of service that describe the standard quantity of supplies that are covered based on the LCD. (**Note:** *The codes must be billed in this specific order on the claim.*) In this situation, the claim line with the GA modifier will be denied as not medically necessary with a "patient responsibility" (PR) message and the claim line with the GK modifier will continue through the usual claims processing. The beneficiary liability will be the sum of (a) the difference between the submitted charge for the GA claim line and the submitted charge for the GK claim line and (b) the deductible and co-insurance that relate to the allowed charge for the GK claim line. (**Note:** *When using the upgrade modifiers, the submitted charge for the upgrade [GA modifier line] - i.e., the quantity of supplies that were provided - may not exceed the Medicare fee schedule allowance for the items.*)

If a supplier wants to provide the excess quantity of supplies without any additional charge to the beneficiary, then no ABN is obtained. The supplier bills the HCPCS code with a GL modifier and bills the units of service that describe the quantity of supplies that are covered based on the LCD. The quantity of supplies that is provided is not billed.

When using an upgrade modifier for excess quantities of test strips, suppliers are not required to include on the claim the brand name of the product(s) or an explanation for why it is considered an upgrade.

Codes with a GK or GL modifier will continue through the usual claims processing. For test strips and lancets, if the units of service on the GK/GL claim line are within the policy guidelines, then that claim line will not hit an edit which is focused on individual claims lines with excess units of service. If no other edits hit the claim line, payment will be made based on the units of service billed for the code with the GK or GL modifier.

Example:

The physician orders testing twice per day for a non-insulin treated patient. The supplier provides 4 vials of test strips (50 in each) and 2 boxes of lancets (100 in each) as a three month supply. The supplier is unable to confirm that there is documentation in the patient's medical record that justifies the need for twice per day testing and/or documentation (e.g., beneficiary log) that the beneficiary is testing at that frequency.

If the supplier wants to collect payment for the excess quantity of supplies from the beneficiary and obtains a properly completed ABN, the claim is billed as:

Line 1 - A4253NUKSGA, 4 UOS, 90 day date span
Line 2 - A4253NUKSGK, 2 UOS, 90 day date span
Line 3 - A4259NUKSGA, 2 UOS, 90 day date span
Line 4 - A4259NUKSGK, 1 UOS, 90 day date span

If the supplier does not want to collect payment for the excess quantity from the beneficiary, no ABN is obtained and the supplier bills:

Line 1 - A4253NUKSGL, 2 UOS, 90 day date span
Line 2 - A4259NUKSGL, 1 UOS, 90 day date span

Refer to the *Glucose Monitors Local Coverage Determination and Policy Article* for additional information on coverage criteria, coding guidelines, and documentation requirements.

Immunosuppressive Drugs Coverage Requirements (DRU)

During recent claim reviews for Immunosuppressive Drugs, the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) noted that suppliers are appending the KX modifier inappropriately. Specifically, suppliers are using the KX modifier when a beneficiary received their transplant prior to Medicare Part A enrollment. According to the Immunosuppressive Drugs Policy Article, coverage of immunosuppressive drugs requires that, in part:

- The patient was enrolled in Medicare Part A at the time of the transplant; and,
- The patient is enrolled in Medicare Part B at the time that the drugs are dispensed.

Immunosuppressive drugs provided to Medicare beneficiaries whose transplant occurred prior to their enrollment in Medicare Part A should not be billed to the DME MAC. For those patients, the drugs may be eligible for coverage under Medicare Part D.

In order to use the KX modifier on a claim line for immunosuppressive drugs, the supplier must have documentation on file to support that the coverage requirements are met. As noted in the local coverage determination (LCD) for Immunosuppressive Drugs Documentation Section:

KX and GY MODIFIERS:
The KX modifier must be added to the claim line(s) for the immunosuppressive drug(s) only if:

a. The supplier obtains from the ordering physician the date of the organ transplant; and,
b. The beneficiary was enrolled in Medicare Part A at the time of the organ transplant (whether or not Medicare paid for the transplant); and,
c. The transplant date precedes the date of service on the claim.

If these three requirements are not met, the KX modifier must not be added to the claim.

Suppliers should refer to the *Immunosuppressive Drugs LCD and related Policy Article* for additional coverage, coding and documentation requirements.

Modifier JW Use (SPE)

The *Medicare Claims Processing Manual* (Internet Only publication 100-4), Chapter 17, Section 40 contains instructions for the use of the JW modifier for discarded drugs and biologicals. The descriptor for the JW modifier reads:

JW - DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT

For NHIC, Corp. DME MAC A claims, the JW modifier is not required for discarded drugs and biologicals.

Suppliers with additional questions should refer to *MLN Matters* articles MM6711 and MM7095 at **http://www.cms.gov/MLNMattersArticles/downloads/MM7095.pdf** and **http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf**

Oral Anti-Emetic Drugs - Coverage Reminder (DRU)

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received questions regarding the coverage requirements in the Oral Antiemetic Drugs (Replacement for Intravenous Drugs) local coverage determination (LCD) and related policy article. Coverage of oral antiemetic drugs is a specific Medicare benefit category found in the *Social Security Act*, Title XVIII, Section 1861(s)(2)(T) with further instructions for coverage in the *Medicare Claims Processing Manual* (CMS Internet-Only Publication 100-4, Chapter 17, Section 80.2).

Questions recently raised relate to the requirement that the oral antiemetic must be initiated within two (2) hours of the administration of the chemotherapeutic agent. This means that the first dose of the oral antiemetic drug or drugs (if part of a multi-drug regimen), must be administered to the beneficiary within 2 hours of initiation of the cancer chemotherapeutic regimen. This *does not* mean that the pharmacy must dispense the drug or fill a prescription within 2 hours of administration of the drug(s). In addition, the amount dispensed must not exceed the maximum dosing time period limitation of 24 or 48 hours as described in the Healthcare Common Procedure Coding System (HCPCS) code descriptor for each drug.

Suppliers should refer to the local coverage determination and related policy article for *Oral Antiemetic Drugs (Replacement for Intravenous Drugs)* for additional coverage, coding and documentation requirements.

Power Wheelchair Rental - Frequently Asked Questions (MOB)

Effective for items provided on or after January 1, 2011, standard power wheelchairs (K0813 - K0831, K0898) must be furnished on a monthly rental basis like other capped rental durable medical equipment (DME). The following are questions and answers from suppliers regarding application of the Power Mobility Devices medical policy and CMS payment policy rules to rented power wheelchairs.

1. When standard power wheelchairs (PWCs) are provided on a rental basis, can they be covered for short term indications?

   Response: No. The change in the payment policy status for power wheelchair does not change the policy statement that PWCs are not covered for patients with short term, reversible conditions.

2. How will the "look back" period affect the review of PWCs?

Response: There is a general policy that coverage of items that are provided on an ongoing basis, including rented DME, is dependent on there being continued need for the item and continued use by the beneficiary. CMS and the DME MACs have not published any information regarding the look back period.

3. A PWC is being rented and the beneficiary goes into a hospital and nursing home for an extended stay. The supplier elects to pick up the wheelchair. When the beneficiary is ready to go back home, would there be a problem with providing a different model wheelchair within the same HCPCS code?

Response: If the supplier chooses to deliver a different model of PWC within the same code, a new detailed product description must be obtained. A new face-to-face (FTF) examination or 7-element order is not needed.

4. If a patient who is renting a PWC moves, is a new in-home assessment required?

Response: No

5. If a patient with a PWC moves and their new home will no longer accommodate the PWC that they have, will Medicare pay for a new PWC?

Response: No. Medicare covers a replacement only if an item is lost, stolen, irreparably damaged, or reaches the 5 year reasonable useful lifetime. Medicare covers a different item only if there is a change in the beneficiary's medical condition.

6. If a patient who is renting a PWC goes into a hospital/nursing home for an extended time and the supplier picks up the wheelchair and the beneficiary is discharged to home, would a new capped rental period start and what documentation would be required?

Response: Standard capped rental rules for beginning a new rental period will apply to power wheelchairs. That policy states that a new capped rental period will begin only if there has been a break in medical necessity of at least 60 days plus the days remaining in the last paid rental month. In the situation that is described, "medical necessity" would continue while the patient was in a facility. If the patient is receiving the same type of PWC (same code) on discharge that they previously had, then the rental period resumes where it left off and no additional documentation is needed (other than a new detailed product description if the make/model of the wheelchair has changed). If the patient needs a different type of PWC on discharge because of a change in their medical condition, all the requirements for a new PWC must be met (i.e., FTF exam, 7-element order, etc.).

7. If, during a capped rental period, a PWC is lost, stolen, or irreparably damaged and a new PWC is provided, does a new CR period start?

Response: Yes. Replacement of power wheelchairs will follow the same rules as any other rented DME item.

8. Is there any situation in which a supplier can be paid for repair to a PWC during a capped period - e.g., if the supplier has information to indicate that the repair is required due to "malicious damage" or "culpable neglect" by the beneficiary?

Response: There can be no payment for the repair of rented items under any circumstances. Reimbursement for repairs is included in the rental payments.

If the supplier believes that a wheelchair repair is required because of malicious damage or culpable neglect by the beneficiary, the supplier can present the information to the DME MAC for investigation. If the DME MAC, in consultation with the CMS, agrees that the beneficiary is responsible for the damage, the supplier can charge the beneficiary.

Power Wheelchairs and Power Operated Vehicles - Documentation Requirements - September 2010 (MOB)

Dear Physician,

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

1. There must be an in-person visit with a physician specifically addressing the patient's mobility needs.
2. There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the patient's mobility limitation and needs. The results of this evaluation must be recorded in the patient's medical record.
3. A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements (see below).
4. The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

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

The complete history and physical examination typically includes:

- History of the present condition(s) and past medical history that are relevant to the patient's mobility needs in the home:
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatment for these symptoms
  - Progression of ambulation difficulty over time
  - Other diagnoses that may relate to ambulatory problems
  - How far the patient can walk without stopping and with what assistive device, such as a cane or walker
  - Pace of ambulation
  - History of falls, including frequency, circumstances leading to falls, and why a walker isn't sufficient
  - What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn't sufficient
  - What has changed to now require use of a power mobility device
  - Ability to use a manual wheelchair
  - Reasons why a power operated vehicle (scooter) would not be sufficient for this patient's needs in the home
  - Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to the patient's mobility needs
  - Weight and height
  - Cardiopulmonary examination
  - Musculoskeletal examination
    - Arm and leg strength and range of motion
  - Neurological examination
    - Gait
    - Balance and coordination
    - **If the patient is capable of walking, the report should include documented observation of ambulation (with use of a cane or walker, if appropriate)**

Examples of vague or subjective descriptions of the patient's mobility limitations include:

- "upper extremity weakness"
- "poor endurance"
- "gait instability"
- "weakness"
- "abnormality of gait"
- "difficulty walking"
- "SOB on exertion"
- "pain"
- "fatigue"

- "deconditioned"

These types of statements are insufficient and do not objectively address the mobility limitation or provide a clear picture of the patient's mobility deficits. Objective measurements should be provided.

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

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

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation - as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

You should record the visit and mobility evaluation in your usual medical record-keeping format. Many suppliers provide forms for you to complete. Suppliers often try to create the impression that these documents are a sufficient record of the in-person visit and medical evaluation. Based upon our auditing experience, most of them are not. That is because they typically contain check-off boxes or space for only brief answers and thus do not provide enough detailed information about the patient's ambulatory abilities and limitations to allow the Medicare contractor to determine if coverage criteria have been met. Forms such as those developed by the Texas or Florida Academy of Family Physicians are designed to gather selected bits of information and are almost always insufficient. What is required is a thorough narrative description of your patient's current condition, past history, and pertinent physical examination that clearly describes their mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs.

You may write a prescription for a power mobility device ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

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

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

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

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

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

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

Sincerely,

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

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

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

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

Results of Widespread Prepayment Review of Claims for HCPCS Code E0570 (SPE)

The DME MAC Jurisdiction A has completed the third quarter prepayment review of claims for Nebulizers, LCD (L11499). The third quarterly findings have included claims with dates of service from July 2010 through October 2010. This review evaluated claims for HCPCS code E0570 (NEBULIZER, WITH COMPRESSOR).

The review involved prepayment complex medical review of 211 claims submitted by 101 suppliers, of which, 68 claims were allowed and 143 were denied, resulting in a 67.7% Claim Denial Rate. Consequently, the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 68.3%.

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

- Insufficient clinical documentation in medical records to support medical necessity (17%)
  - No reference to payable diagnosis or condition requiring nebulizer use
  - No physical findings on exam justifying use of a nebulizer
  - Documentation states patient is no longer using their nebulizer by MD advice or non-compliance
  - Documentation focuses only on other medical issues that are unrelated to nebulizer treatment
  - Physician did not sign clinical documents, exam reports or progress notes that he/she inititiated
- No medical records were received with the claim for clinical review (64%)
- No proof of delivery to support the item ordered was received by the beneficiary (6%)
- No detailed order was available or detailed order received was incomplete, i.e., no patient name, no MD signature, incomplete description of the items ordered and orders undated (13%)

Documentation **must** include:

- A detailed order that includes the following:
  - Patient name
  - The description of item to be dispensed
  - The ordering physician's legible signature
  - The date of the ordering physician's signature

  Note: *A new order is required every 12 months for All Inhalation Drugs (even if the prescription has not changed)*
- Clinical records
- Payable Diagnosis
- Delivery slip
- Signature requirements

Suppliers are reminded that documentation must be made available to the DME MAC upon request and submitted timely to avoid claim denials. Please refer to the Documentation Requirements section of the Nebulizer LCD (L11499), which states in part:

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

Suppliers are also encouraged to visit the DME MAC Web site on a regular basis to remain current with the latest information regarding LCDs for Jurisdiction A. In addition the following educational articles are relevant to payment of nebulizer claims: "**July 2010 Cert Errors**" and "**Documentation Reminder - Order Requirements**".

Additional information on documentation requirements may be found on the NHIC Medical Review web site at:
http://www.medicarenhic.com/dme/medical_review/mr_index.shtml

---

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

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from April 01, 2010 through June 30, 2010 and resulted in a 75.3% Charge Denial Rate (CDR).

DME MAC A recently concluded the quarterly review for claims paid from July 1, 2010 through September 30, 2010 and identified the following:

- This review involved prepayment complex medical review of 952 claims submitted by 257 suppliers, of which, 356 claims were allowed and 596 were denied resulting in a claim denial rate of 62.6%. Consequently, the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 58.8%.

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

- Incomplete documentation (63.2%)
  - One or more of required documents were not provided with documentation, such as no 7 element order / prescription included; no detail product description included; no physician Face to Face examination / mobility evaluation available for review; no proof of a home evaluation / assessment being completed; no attestation statement of financial relationship provided from the specialty evaluator.
  - 7 element order / prescription missing one or more of the seven required elements i.e., (date of face to face, length of need for the PMD, description of item ordered, patient name, patient's diagnosis, ordering clinician's signature and date of order.
  - Detail product description not signed or signature and/or date illegible, allowance amounts not included, dated prior to completion of face to face / mobility evaluation.
  - No received date indicators from the suppliers as required by LCD.
- Documentation available for review could not justify medical necessity. (12.8%)
  - Documentation did not include clinical records from a Face to Face mobility exam by the ordering clinician, but only an attestation statement claiming that the beneficiary requires a PWD.
  - Face to Face exam did not include a comprehensive mobility exam that addresses the patient's specific mobility related abilities and limitations, i.e., upper and lower body strength, range of motion, physical endurance and ability to attend to and complete MRADL's.
  - Documentation submitted failed to establish medical necessity for PMD. Sufficient objective measurements were not provided. Documentation was unclear as to the beneficiary's actual mobility status.
  - Documentation reported the beneficiary has the ability to ambulate, utilizing a walker and/or manual wheelchair.
- Other (4.2%)
  - Duplicate claim submission. Claim had been previously submitted and reviewed.

- Supplier failed to stamp/date or equivalent receipt of 7 element orders within 45 day time frame after the completion of the F2F exam.
- No documentation, at all was submitted with the claim.
- Supplier sent written statement that the claim was billed in error, i.e, Supplier did not realize beneficiary was in hospice or a nursing home at the time of the order.

Based on the above quarterly CDR, DME MAC A will continue to review claims billed with HCPCS K0823.

Suppliers are reminded to reference the following publications for documentation requirements. The January 11, 2008 educational article Power Mobility Devices Billing Reminder (**http://www.medicarenhic.com/dme/articles/011108_pmd.pdf**), November 05, 2009 educational article Power Mobility Devices - 7-Element Order (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf**), and the Power Mobility Devices (L21271) LCD (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**).

Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (OXY)

- E1390 (Oxygen Concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate)
- E0431 (Portable gaseous oxygen system, rental: includes portable container, regulator flowmeter, humidifier, cannula or mask, and tubing
- E0439 (Stationary liquid oxygen system, rental includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing.

DME MAC A concluded a quarterly medical review of claims for the above HCPCS codes, covering a period from July 01, 2010 through September 30, 2010 and identified the following:

This review involved prepayment complex medical review of 478 services submitted by 91 suppliers, of which 102 (21%) services were allowed and 376 (79%) services were denied. Consequently, the total denied allowed amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowed amount of services medically reviewed) resulted in an overall Charge Denial Rate of 71%.

Based on review of the documentation received, the following are the primary reasons for services denied.

- Documentation - 55%:
  - Lacking any or all of the following: 30 day initial, 90 day recertification or ongoing Physician clinical visit.
  - Physician signature requirements not met:
    - Illegible
    - Name stamped
  - No Recertification CMN
- Determined to be Medically Unnecessary - 5%
  - Patient does not meet the criteria for home oxygen therapy - Test results do not qualify patient
  - Provider's clinical records do not support the medical necessity for home oxygen. Comprehensive records not submitted
- Other - 19%
  - No response to documentation request
  - Claims billed in error
  - No clinical documentation returned with ADR letter

Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768). **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

- The *DME MAC Jurisdiction A Supplier Manual*:
  http://www.medicarenhic.com/dme/suppmandownload.shtml
  - "Welcome Page" provides valuable information to CMS Web sites.
  - Chapter 10: Includes information regarding documentation requirements.

Suppliers are also encouraged to visit the DME MAC Web site (**http://www.medicarenhic.com/dme/**) on a regular basis to remain current with the latest information regarding the LCDs for Jurisdiction A.

Submitting Diabetic Shoe Inserts for Coding (O&P)

Diabetic inserts coded as A5512 and A5513 must meet the material thickness and Shore A durometer scale hardness measurements outlined in the Local Coverage Determination and Policy Articles for Therapeutic Shoes for Persons with Diabetes.

For inserts to be coded as A5512, the product must be a heat moldable "base layer" with a material thickness of at least 1/4 of an inch of 35 Shore A or higher or at least 3/16 of an inch of 40 Shore A or higher, be coded by the PDAC, and be listed on the Product Classification List. **A sample pair of inserts must be submitted with the Coding Verification Application.** Applications are available on the PDAC web site at **http://www.dmepdac.com**.

For inserts to be coded as A5513, the product must retain its shape during use for the life of the insert. The base layer material must be 35 Shore A or higher. The central portion of the base layer of the heel must be at least 1/16 of an inch on the finished product, be coded by the PDAC, and be listed on the Product Classification List. **Manufacturers/central fabrication facilities must submit a 4 x 4 x ½ inch sample of base layer material(s), a sample pair of inserts, a narrative description and pictures of the manufacturing process, and a completed Coding Verification Application.** Applications are available on the PDAC web site at **http://www.dmepdac.com**. A copy of the original Coding Verification Letter to the manufacturer/ central fabrication facility, approving the product as A5513, must be kept on file and available to distributors, suppliers, and CMS contractors upon request.

Practitioners who create custom fabricated inserts from raw materials for dispensing directly to the end user (the beneficiary) are not required to have their insert listed on the PDAC web site in order to bill using code A5513. However, a coding verification request may be submitted to the PDAC to ensure accuracy of the code for the item provided. **If a Coding Verification Review is requested, a 4 x 4 x ½ inch sample of base layer material(s), a sample pair of inserts, a narrative description and pictures of the manufacturing process, and a completed Coding Verification Application must be submitted.**

Coding verification results are subject to review and observation by CMS and its contractors, including the PDAC, DME MAC, PSC, and ZPIC contractors.

Suppliers are reminded to access the PDAC's Durable Medical Equipment Coding System (DMECS) **https://www.dmepdac.com/dmecs/index.html** for any questions regarding the correct coding of products. Or, call the PDAC Contact Center at: 877-735-1326

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

Therapeutic Shoes for Diabetics - Physician Documentation Requirements (SPE)

Dear Physician,

Medicare covers therapeutic shoes and inserts for persons with diabetes. This statutory benefit is limited to one pair of shoes and up to 3 pairs of inserts or shoe modifications per calendar year. However, in order for these items to be covered for your patient, the following criteria must be met:

- An M.D. or D.O. (termed the "certifying physician") must be managing the patient's diabetes under a comprehensive plan of care and must certify that the patient needs therapeutic shoes.
- That certifying physician must document that the patient has one or more of the following qualifying conditions:
  - Foot deformity
  - Current or previous foot ulceration
  - Current or previous pre-ulcerative calluses
  - Previous partial amputation of one or both feet or complete amputation of one foot
  - Peripheral neuropathy with evidence of callus formation
  - Poor circulation

According to Medicare national policy, it is not sufficient for a podiatrist, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) to provide that documentation (although they are permitted to sign the order for the shoes and inserts). The certifying physician must be an M.D. or D.O.

The following documentation is required in order for Medicare to pay for therapeutic shoes and inserts and must be provided by the physician to the supplier, if requested:

1. **A detailed written order.** This can be prepared by the supplier but must be signed and dated by you to indicate agreement.

2. **A copy of an office visit note from your medical records that shows that you are managing the patient's diabetes.** This note should be within 6 months prior to delivery of the shoes and inserts.

3. **Either (a) a copy of an office visit note from your medical records that describes one of the qualifying conditions or (b) an office visit note from another physician (e.g., podiatrist) or from a PA, NP, or CNS that describes one of the qualifying conditions.** If option (b) is used, you must sign, date, and make a note on that document indicating your agreement and send that to the supplier.

   The note documenting the qualifying condition(s) must be more detailed than the general descriptions that are listed above. It must describe (examples not all-inclusive):
   - The specific foot deformity (e.g., bunion, hammer toe, etc.); or
   - The location of a foot ulcer or callus or a history of one these conditions; or
   - The type of foot amputation; or
   - Symptoms, signs, or tests supporting a diagnosis of peripheral neuropathy plus the presence of a callus; or
   - The specifics about poor circulation in the feet - e.g., a diagnosis of venous or arterial insufficiency or symptoms, signs, or test documenting one of these diagnoses. A diagnosis of hypertension, coronary artery disease, or congestive heart failure or the presence of edema are not by themselves sufficient.

4. **A certification form stating that the coverage criteria described above have been met.** This form will be provided by the supplier but must be completed, signed, and dated by you after the visits described in #2 and 3. If option 3(b) is used, that visit note must be signed prior to or at the same time as the completion of the certification form. **However, this form is not sufficient by itself to show that the coverage criteria have been met, but must be supported by other documents in your medical records - as noted in #2 and 3.**

New documentation is required yearly in order for Medicare to pay for replacement shoes and inserts.

Physicians can review the complete Local Coverage Determination and Policy Article titled *Therapeutic Shoes for Persons with Diabetes* on the NHIC Web site at **http://www.medicarenhic.com** viewed in the local coverage section of the Medicare Coverage Database at **http://www.cms.gov/mcd/search.asp**

Suppliers may ask you to provide the medical documentation described above on a routine basis in order to assure that Medicare will pay for these items and that your patient will not be held financially liable. Providing this documentation is in compliance with the HIPPA Privacy Rule. No specific authorization is required from your patient. Also note that you may not charge the supplier or the beneficiary to provide this information. Please cooperate with the supplier so that they can provide the therapeutic shoes and inserts that are needed by your patient.

Sincerely,

Paul J. Hughes, MD
NHIC DME MAC Jurisdiction A
Medical Director
75 William B. Terry Drive
Hingham, MA 02043

Tracheostomy Care Supplies Widespread Review: Notification of Continuation of Complex Review (SPE)

NHIC recently conducted a widespread prepayment review for HCPCS Codes:

- A4623 Tracheostomy, Inner Cannula
- A4629 Tracheostomy Care Kit for Established Tracheostomy

The results of the review were posted on NHIC web site on August 27, 2010. In the review, 100 claims were reviewed with 65 being denied; resulting in a 66.86% charge denial rate. Based on the outcome of the review, NHIC will continue with a widespread complex review on claims billed with HCPCS Codes A4623 and A4629.

Suppliers are reminded they will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 30 days of the date on the letter may result in claim denial.

It is important for suppliers to be familiar with the documentation requirements outlined in the *LCD for Tracheostomy Care Supplies* (L11536) and related Policy Article.

Treprostinil Inhalation Solution (Tyvaso®) - Coverage (DRU)

Effective for dates of service on or after January 01, 2011, least costly alternative payment policy will no longer be applied to the nebulizer used to administer treprostinil inhalation solution. This information will be added to the next revision of the Nebulizers policy.

For additional coverage, coding, and documentation requirements, suppliers should refer to the Nebulizer LCD and related Policy Article on the DME MAC web sites. Additional information specific to the coverage and coding of treprostinil was also published in August 2010 in an article titled *Treprostinil Inhalation Solution (Tyvaso®) - Coverage and Coding*.

Wheelchair Options and Accessories - LT and RT modifiers (MOB)

The Wheelchair Options and Accessories Policy Article currently states:

> The right (RT) and left (LT) modifiers must be used when appropriate. If bilateral items (left and right) are provided as a purchase and the unit of service of the code is "each" bill both items on the same claim line using the LTRT modifiers and 2 units of service. If bilateral items are provided as a rental and the unit of service is "each", bill the items on two separate claim lines with the RT modifier on one line and the LT modifier on the other. If bilateral items are provided as a purchase or rental and the unit of service is "pair", bill both items on the same claim line using the LTRT modifiers and 1 unit of service.

The Policy Article is being revised to remove the requirement to report the LT and RT modifiers when the unit of service of the code is "pair". The revised last sentence will state:

> If bilateral items are provided and the unit of service is "pair", the LT and RT modifiers do not need to be reported.

This applies to HCPCS codes E1010 (power leg elevation system), K0020 (fixed, adjustable height armrests), and K0195 (elevating legrests - for use with capped rental wheelchair base).

This change is effective immediately and will be incorporated in a future revision of the *Wheelchair Options and Accessories Policy Article*.

Widespread Prepayment Probe for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (PEN)

DME MAC A will be initiating a widespread prepayment probe of claims for B9000 (Enteral nutrition infusion pump - without alarm) and B9002 (Enteral nutrition infusion pump - with alarm). This review is being initiated due to a high volume of claims.

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 the LCD for Enteral Nutrition (L5041):

1. Documentation of dispensing (verbal) order (if item(s) were dispensed based on a verbal order)
2. Detailed written physician order
3. A completed DME Information Form (DIF) for the Enteral Nutrition (CMS Form 10126)
4. Medical record information to support policy coverage criteria for the enteral nutrition are met per LCD L5041
5. Medical record information to support policy coverage criteria for the enteral nutrition infusion pump are met per LCD L5041
6. Proof of delivery

To avoid unnecessary denials for missing or incomplete information, please ensure when submitting documentation requests that all requested information is included with your file and respond in a timely manner.

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 LCD for Enteral Nutrition (L5041) on the NHIC Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

Reminder - Responsibility of Third Parties to Notify Contractors of Deceased DMEPOS Supplier Associates (CR6714) (GEN)

NHIC, Corp. DME MAC A is publishing this reminder article in accordance with *Change Request 6714* (**http://www2.cms.gov/transmittals/downloads/R357PI.pdf**) to advise third-parties such as state provider associations, state medical societies, academic medical institutions, group practices, etc., of the need to promptly inform the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC) or the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) of the death of DMEPOS supplier associates. A DMEPOS supplier associate is defined as an owner, authorized official, or delegated official of a DMEPOS supplier.

Prompt notification ensures accurate enrollment and payment information and also helps prevent others from utilizing the enrollment data of deceased individuals.

For additional information on third-party notification of a deceased DMEPOS supplier associate, access the CMS *Program Integrity Manual* - Publication 100-08, Chapter 15, Section 28, Subsection C (**http://www.cms.gov/manuals/downloads/pim83c15.pdf**).

Mark Your Calendars to Participate in the Next Quarterly Ask-the-Contractor Teleconference for Jurisdiction A DME MAC (GEN)

The Jurisdiction A DME MAC Provider Outreach & Education Team will host an open forum DMEPOS Ask-the-Contractor Teleconference (ACT) and Webinar on **Thursday, December 16, 2010**. During this call, DME MAC A will provide a brief overview of general updates/reminders followed by an open question and answer period. The call will begin promptly at **11:00AM EST** and last for approximately one hour. **To participate, webinar registration is required at https://www2.gotomeeting.com/register/539729771**

The teleconference forum promotes an opportunity to share information, answer questions, and identify problems in a timely way. Participants learn from each other's questions and receive useful clarifications regarding the different rules and instructions associated with Fee-for-Service Medicare coverage, coding, and payment. All DMEPOS supplier types are encouraged to participate.

Additional ACT call details are available at **http://www.medicarenhic.com/dme/dme_act.shtml#upcoming**

Ask-the-Contractor Teleconference (ACT) Q&A - September 09, 2010 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Thursday, September 09, 2010 as a teleconference/webinar. A presentation of general updates and hot topics was provided followed by an open Q&A chat session. As participants submitted questions via the webinar chat mechanism staff responded by sharing pertinent questions and the answers with the entire audience. In addition, many questions were also submitted during the registration process which enabled DME MAC A staff to provide verbal responses to everyone during the call.

Note: *Some questions may be rewritten to establish clarity. In addition, individual claim specific questions, questions not general in nature and questions that did not make sense are not included in this document. As advised during the call, please contact Customer Service to address these types of questions.*

Q1: When we submit audit request documentation does Medicare keep hard copy of records?

A1: We would have either a hard copy or legal scanned copy.

Q2: What information is needed to justify continued need for rental items such as oxygen, nebulizers, CPAP, wheelchairs, and hospital beds and recurring supplies such as glucose test strips, urological supplies, and ostomy supplies?

A2: In order to justify continued need, the supplier must obtain medical documentation from the physician that would include specific details noting the patient's continued need. The physician should regularly discuss with their patients the pattern of usage of ordered equipment/supplies. This review should be no different than the ordering physician's review of the continued need for medication or other treatments.

A series of "Dear Physician" letters were developed to assist suppliers in requesting pertinent documentation and are available on the DME MAC A Web site at: **http://www.medicarenhic.com/dme/phy_letters.shtml** A letter specific to continued need was published March 19, 2010.

Q3: Where can I find the error code manual for front end rejections for electronic claims?

A3: The error code manual is available on the CEDI Web site at: **http://www.ngscedi.com/outreach_materials/CEDIFrontEndReportsManual.pdf**

Q4: Why does a physician office who is supplying the DME need to write up a separate written order from the office note?

A4: If the ordering physician is the supplier, a separate order is not required, but the item provided must be clearly noted in the patient's record. Keep in mind the laws specific to self referrals and items provided incident to a physician's service. When urological supplies are furnished in a physician's office, they may be billed only if the patient's condition meets the definition of permanence. (In this situation, the catheters and related supplies are covered under the prosthetic device benefit.) If the patient's condition is expected to be temporary, urological supplies may not be billed. (In this situation, they are considered as supplies provided incident to a physician's service and payment is included in the allowance for the physician services, which are processed by the local carrier.) When billing for urological supplies furnished in a physician's office for a permanent impairment, use the place of service code corresponding to the beneficiary's current place of residence; do not use POS 11, office.

Q5: Will Medicare allow a CPAP user more time after the 12 week trial has expired in order to become compliant?

A5: Per the **LCD for Positive Airway Pressure Devices**, beneficiaries who fail the initial 12 week trial are eligible to re-qualify for a PAP device but must have both:

1. Face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and
2. Repeat sleep test in a facility-based setting (Type 1 study)

Q6: Can I check the web and/or the IVR to see if a patient is on Home Health Care or if they got a pair of shoes within the last 12 months?

A6: The Home Health details that are currently available in the DME MAC A IVR are the home health name, address, and effective/termination dates.

Unfortunately, at this time the IVR is unable to search for same/similar items for HCPCS codes beginning with A, L or V. Providers must speak with a live customer service representative to obtain information on HCPCS codes beginning with the A, L or V.

Q7: Is the oral anticancer drug Capecitabine billed using an NDC or a HCPCS code?

A7: National Drug Codes (NDCs) may be billed only when the drug is used as an oral anticancer drug. The NDC is a number, which uniquely identifies a manufacturer's product in terms of the strength of each tablet/capsule, quantity of tablets/capsules

in a package, and other packaging details. For all NDC numbers, 1 unit of service = 1 tablet or 1 capsule. Suppliers must use the NDC that matches the product dispensed.

A list of valid NDC numbers for covered oral anticancer drugs is located on the Pricing, Data Analysis and Coding (PDAC) Contractor Web site (**http://www.dmepdac.com**) under NDC to HCPCS Crosswalk.

Q8: If the ordering physician's signature is illegible on a computer generated prescription/order where the ordering provider's name is printed on the form, but not necessarily underneath the signature, does this meet the requirements for a valid signature?

A8: The signature must be legible or you must have a signature log to confirm the signature.

Q9: When will the new Medicare DME MAC Redetermination Request Form be available?

A9: The new form was posted to the DME MAC A Web site on September 15, 2010. You can access this form at: **http://www.medicarenhic.com/dme/dme_forms.shtml**

Q10: What type of documentation is required at least every 6 months when the treating physician has ordered a frequency of testing that exceeds the utilization guidelines?

A10: Per the **LCD for Glucose Monitors**, if refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

Q11: Where can I find information on how to bill rental equipment that is replaced within the five years reasonable useful lifetime (RUL)? I am having a difficulty understanding what modifiers should be used.

A11: Medicare will not cover replacement of rental equipment within the 5 year RUL except in cases where the equipment is irreparably damaged by a specific event (i.e. fire, flood, natural disaster), lost or stolen.

Q12: Do we need to collect patient testing logs for each refill of diabetic supplies and are we required to have this in our possession at all times?

A12: No. Patient testing logs do not need to be collected for each refill and are only required on a regular basis (every 6 months) when the physician has ordered an amount of supplies that exceed the utilization guidelines set forth in the LCD. The point at which you chose to collect this information is a business decision; however, it is recommended that you have the necessary documentation on hand sooner rather than later in the event that an audit.

Q13: If we scan everything into our system, are we required to keep paper originals on file?

A13: It is recommended that you seek professional legal assistance on this matter.

Q14: When utilizing a shipping service for delivery, must we always bill with the ship date as the first date of service? Can dates overlap previous usage periods and still be paid.

A14: Yes. The dates can overlap no more than five days in special circumstances; however, this should not be occurring on a regular basis.

Q15: If a minor replacement part is needed is a physician order required?

A15: No; however, if the entire item needs to be replaced or a major component needs to be replaced that initially required an order, then an order would be required for replacement.

Q16: What is the proper placement of the modifiers when billing the 99 modifier?

A16: It is necessary to report modifier 99 in the fourth modifier position on the line of service.

Third Quarter 2010 - Top Claim Submission Errors

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for July through September 2010 are provided in the following table.

Note: *Due to the transition to CEDI, the data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher.*

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 - Invalid Procedure Code and/or Modifier	225,713	The procedure code, modifier, or procedure code and modifier combination is invalid.
C095 - Diagnosis Code Invalid - Pointer 1	50,901	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
C044 - Subscriber Primary ID Invalid	43,371	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	42,351	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	37,397	There is no link between the NPI that was submitted and a PTAN/NSC.
C171 - Capped Rental - Modifier Missing	36,944	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.
C143 - Ordering Provider ID Qualifier Invalid	33,492	The Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line.
B108 - Billing provider not authorized for submitter	26,801	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C179 - Service From/To Dates Not Equal	21,396	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.
C046 - Diagnosis Code 2 Invalid for Date of Service (DOS)	20,657	The second diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's date of service.

Third Quarter 2010 - Top Return/Reject Denials

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the third quarter of 2010. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and

necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from July through September 2010.

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.	38,145
CO 182 N56 - Procedure modifier was invalid on the date of service.	**Item 24D** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	11,578
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.	2,936
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.	2,533
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).	2,512
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.	1,299
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.	785
CO 16 M51, N225, N29 - Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	739
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.	632
CO 16 N51 - Electronic interchange agreement not on file for provider/submitter.	The PTAN/NSC on file is not eligible to submit electronic claims.	510

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!

Pharmacy Attestation Information (GEN)

The National Supplier Clearinghouse (NSC) recently published a ListServe with the following information regarding pharmacy accreditation exemption:

> As of January 1, 2011, pharmacies that meet all of the criteria may file an accreditation exemption statement which enables them to be enrolled in Medicare to supply durable medical equipment, orthotics, prosthetics and supplies (DMEPOS) which require accreditation, without having an accreditation.

Pharmacies must complete and submit an attestation statement to the NSC. Full exemption criteria along with the attestation statement are available on the NSC Web site at
http://www.palmettogba.com/palmetto/providers.nsf/ls/National%20Supplier%20Clearinghouse~8B4SJJ8882?opendocument

---

Now Available from the National Supplier Clearinghouse (NSC) - October 2010 Newsletter (GEN)

The NSC recently published its October 2010 newsletter edition which includes relevant details on many industry hot topics. Some of the topics included in the latest edition are:

- Enhanced/Modified Supplier Enrollment Standards
- Internet-based PECOS
- Site Inspections
- Reporting Changes of Information
- Enhanced NSC IVR

To view this newsletter in its entirety, visit the NSC Web site at:
http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/89TPRU3481

DME MAC A's Gift Policy (GEN)

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

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

2011 Jurisdiction A DME MAC Holiday Schedule (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) will be observing the following holidays in 2011:

Holiday	Date
New Year's Day	Monday, January 3
Martin Luther King, Jr. Day	Monday, January 17
Memorial Day	Monday, May 30
Independence Day	Monday, July 4
Labor Day	Monday, September 5
Veterans Day	Friday, November 11
Thanksgiving	Thursday, November 24
Friday after Thanksgiving	Friday, November 25
Christmas Eve	Friday, December 23
Company-designated Floating Holiday	Friday, December 30

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.gov/QuarterlyProviderUpdates/**. CMS encourages you to bookmark this Web site and visit it often for this valuable information.

DME MAC A ListServes (GEN)

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

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

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

Supplier Manual News (GEN)

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

Updates/Corrections Made:
In October of 2010 chapter 2 was updated and in December of 2010 chapters 1, 3, 8, 9 and 10 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.

Quiz yourself and your staff.
Visit the DME MAC A Test Your Knowledge Quizzes today at:
http://www.medicarenhic.com/dme/dme_quiz_index.shtml

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:
NHIC, Corp.
P.O. Box 809252
Chicago, IL 60680-9252

Payment Offset Fax Requests: 781-741-3916

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

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Redetermination Requests Fax: 781-741-3118

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

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

Faxed Reopenings: 781-741-3914

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:

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

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Mailing Address:

Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:

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

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

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

DME MAC Jurisdiction A Resource

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

December 2010
Number 18

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.gov/

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

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

DME MAC Jurisdiction A Resource Coordinator
Outreach & Education Publications
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 02043

NHIC, Corp.
A CMS Contractor

75 Sgt. William B. Terry Drive
Hingham, MA 02043