DME MAC Jurisdiction A Resource

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

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Billing/Finance

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

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Addition of Repair Codes to the List of Healthcare Common Procedure Coding System (HCPCS) Codes Payable Under the Instructions Provided in Change Requests (CRs) 6573 and 5917 (MM6914) (GEN)

MLN Matters® Number: MM6914
Related CR Release Date: April 30, 2010
Related CR Transmittal #: R695OTN

Related Change Request (CR) #: 6914
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

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

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued CR 6914 in order to augment previously issued CR 6573. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) **suppliers may bill separately for any of the repair codes listed in the Key Points section of this article in addition to the codes for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME previously communicated in Attachment A of CR 6573**. Your Medicare contractors will reprocess any claims submitted by DMEPOS suppliers for these separately billable repair codes listed below with dates of service of January 1, 2010, through the implementation date of CR 6914 (which is October 4, 2010), according to the guidelines established in CRs 5917 and 6573.

Key Points of CR6914

- The following is the list of the additional separately billable repair codes issued within CR6914

Code	Description
K0739	REPAIR OR NON-ROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT OTHER THAN OXYGEN EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES
L7500	REPAIR OF PROSTHETIC DEVICE, HOURLY RATE
L7510	REPAIR OF PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT, PER 15 MINUTES
L8627	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR, COMPONENT, REPLACEMENT
L8628	COCHLEAR IMPLANT, EXTERNAL CONTROLLER COMPONENT, REPLACEMENT
L8629	TRANSMITTING COIL AND CABLE, INTEGRATED, FOR USE WITH COCHLEAR IMPLANT DEVICE
Q0506	BATTERY, LITHIUM-ION, FOR USE WITH ELECTRIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY

- Medicare contractors will allow suppliers that are dually enrolled with the National Supplier Clearinghouse (NSC) and with their local carrier or A/B MAC as DMEPOS suppliers to bill separately for any of the above listed DMEPOS repair codes as well as those codes included in Attachment A of CR 6573 when billed under the guidelines established in CRs 5917 and 6573, including items/services furnished to beneficiaries who reside in other States.

- CR 5917 may be reviewed at **http://www.cms.gov/Transmittals/downloads/R1603CP.pdf** and CR 6573 **http://www.cms.gov/Transmittals/downloads/R531OTN.pdf** on the CMS website.

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

The official instruction associated with this CR6914, issued to your Medicare MAC or carrier regarding this change may be viewed at **http://www.cms.gov/transmittals/downloads/R695OTN.pdf** on the CMS website.

You may review MM6573 (related to CR 6573) at **http://www.cms.gov/MLNMattersArticles/downloads/MM6573.pdf** and MM5917 (related to CR 5917) at **http://www.cms.gov/MLNMattersArticles/downloads/MM5917.pdf** on the CMS website.

Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prostheses Healthcare Common Procedure Coding System (HCPCS) Code (MM6743) (SPE)

MLN Matters® Number: MM6743
Related CR Release Date: April 29, 2010
Related CR Transmittal #: R686OTN
Related Change Request (CR) #: 6743
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected
This article is for physicians, non-physician practitioners and suppliers submitting claims to Medicare contractors (Medicare Administrative Contractors (MACs), carriers and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for tracheo-esophageal voice prostheses provided to Medicare beneficiaries.

Provider Action Needed
This article is based on change request (CR) 6743, which changes the claims filing jurisdiction for Healthcare Common Procedure Coding System (HCPCS) code L8509. HCPCS code L8509 describes a tracheo-esophageal voice prosthesis inserted by a licensed health care provider, any type. This device is inserted in a physician's office or other outpatient setting. Effective for dates of service on or after October 1, 2010, claims for HCPCS code L8509 must be submitted to the A/B MAC or Part B carrier, as applicable, instead of the DME MAC. This jurisdictional policy does not apply to tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting (HCPCS code L8507). The filing jurisdiction for these claims remains with the DME MACs. Be sure billing staff know of this change.

Key Points of CR 6743

- Effective for dates of service on or after October 1, 2010, the DME MACs will deny claims containing HCPCS code L8509 as not payable under the contractor's claims jurisdiction area. When Medicare denies such claims, the provider will receive these messages: remark code N418 (Misrouted claim. See the payer's claim submission instructions.) and reason code 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.).

- Effective for dates of service on or after October 1, 2010, the A/B MACs and Part B carriers will accept HCPCS code L8509 for processing.

- The A/B MACs and Part B carriers will cover claims for HCPCS code L8509 as a prosthetic device. The A/B MACs and Part B carriers will base the Medicare allowed payment amount on the lower of the actual charge or the fee schedule amount for HCPCS code L8509.

- Tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting are billed using HCPCS code L8507 (tracheo-esophageal voice prostheses, patient inserted, any type, each) and are eligible for coverage under the prosthetic device benefit. The filing jurisdiction for these claims remains with the DME MACs.

- Medicare does not cover the item if it is shipped or dispensed to the beneficiary, who then takes the item to their physician's office for insertion. The A/B MACs or Part B carriers will deny claims in these instances, as described in Chapter 15, Section 120, in, the *Medicare Benefit Policy Manual*, which states that "*Medicare does not cover a prosthetic device dispensed to a*

patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient's condition."

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

The official instruction, CR6743, issued to your, A/B MAC, carrier and/or DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R686OTN.pdf** on the CMS website.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (MM6901) (GEN)

MLN Matters® Number: MM6901
Related CR Release Date: April 23, 2010
Related CR Transmittal #: R1950CP
Related Change Request (CR) #: 6901
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected
This article is for physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed
CR 6901, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective July 1, 2010. Be sure billing staff are aware of these changes.

Background
The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC and CARC lists are updated 3 times a year - in March, July, and November. Both code lists are posted at **http://www.wpc-edi.com/Codes** on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6901.

CR 6901 conveys the following updates:

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1/24/2010
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1/24/2010

Modified Codes - CARC
None

Deactivated Codes - CARC
None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.	YES
N524	Based on policy this payment constitutes payment in full.	NO
N525	These services are not covered when performed within the global period of another service.	NO
N526	Not qualified for recovery based on employer size.	YES
N527	We processed this claim as the primary payer prior to receiving the recovery demand.	YES
N528	Patient is entitled to benefits for Institutional Services.	YES
N529	Patient is entitled to benefits for Professional Services.	YES
N530	Our records indicate a mismatch in enrollment information for this patient.	YES
N531	Not qualified for recovery based on direct payment of premium.	YES
N532	Not qualified for recovery based on disability and working status.	YES

Modified Codes - RARC

Code	Modified Narrative	Medicare Initiated
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package	NO
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	NO

Deactivated Codes - RARC
None

Additional Information
To see the official instruction (CR6901) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC, refer to **http://www.cms.gov/Transmittals/downloads/R1950CP.pdf** on the CMS website.

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

Claim Status Category Code and Claim Status Code Update (MM6859) (GEN)

MLN Matters® Number: MM6859
Related CR Release Date: March 26, 2010
Related CR Transmittal #: R1936CP
Related Change Request (CR) #: 6859
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

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

Provider Action Needed
This article, based on CR6859, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2010 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on the Internet on or about March 1, 2010. At the January 2010 meeting, the committee also decided to allow the industry 6 months for implementation of newly added or changed codes. 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 July 6, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

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). 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 Centers for Medicare & Medicaid Services (CMS) website.

The official instruction, (CR6859), issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R1936CP.pdf** on the CMS website.

Discarded Drugs and Biologicals Updates (MM6711) (DRU)

MLN Matters® Number: MM6711 Revised
Related CR Release Date: April 30, 2010
Related CR Transmittal #: R1962CP
Related Change Request (CR) #: 6711
Effective Date: July 30, 2010
Implementation Date: July 30, 2010

Note: *This article was revised on May 21, 2010, to clarify that your Medicare contractor may require the use of the JW modifier.*

Provider Types Affected
Physicians, hospitals, suppliers and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Part A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for administering or supplying drugs and biologicals should review this article.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued CR 6711 to include in the *Medicare Claims Processing Manual* the updated policy, which describes when to use the JW modifier for discarded drugs.

Background
As a reminder, your Medicare contractor may require its providers to use the JW modifier. If required, when billing Medicare for all drugs except those provided under the Competitive Acquisition Program for Part B drugs and biologicals, use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the discarded drug or biological.

> For example, a single use vial labeled to contain 100 units of a drug, where 95 units are used and billed and paid on one line, the remaining 5 units will be billed and paid on another line using the JW modifier. The JW modifier is only applied to units not used. NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

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

The official instruction, CR6711, issued to your Medicare FI, carrier, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R1962CP.pdf** on the CMS website.

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

MLN Matters Number: SE1011
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

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, 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 website, 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.

* 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.

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

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 website.

Expansion of the Current Scope of Editing for Ordering/Referring Providers for claims processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs) (MM6417) (GEN)

MLN Matters® Number: MM6417 Revised
Related CR Release Date: February 26, 2010

Related CR Transmittal #: R642OTN

Related Change Request (CR) #: 6417
Effective Dates: Phase 1: October 5, 2009,
Phase 2: January 3, 2011
Implementation Dates: Phase 1: October 5, 2009,
Phase 2: January 3, 2011

Note: *This article was revised on March 30, 2010, to reflect the changes in the release of a new CR 6417 on February 26, 2010. The implementation date for some of the requirements of Phase 2 is being changed from April 5, 2010, to January 3, 2011 (see page 3, third bullet). The Transmittal number, CR release date and Web address for accessing the CR has also been changed. All other information remains the same.* ***However, it is extremely important to read MLN Matters® Special Edition article, SE1011, at http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf to see important clarifying information regarding this issue.***

Provider Types Affected
Physicians, non-physician practitioners, and other Part B providers and suppliers submitting claims to carriers or Part B Medicare Administrative Contractors (MACs) for items or services that were ordered or referred. (A separate Article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421. That article is at **http://www.cms.gov/MLNMattersArticles/downloads/MM6421.pdf** on the CMS website.)

Provider Action Needed
This article is based on change request (CR) 6417, which requires Medicare implementation of system edits to assure that Part B providers and suppliers bill for ordered or referred items or services **only** when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners who order or refer must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty who are eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact Part B provider and supplier claims for ordered or referred items or services that are received and processed on or after October 5, 2009.

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

The providers who can order/refer are:

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

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

Key Points

- **During Phase 1 (October 5, 2009- January 2, 2011):** If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. If the ordering/referring provider is not in PECOS the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice.

- **During Phase 2, (January 3, 2011 and thereafter):** If the billed item or service requires an ordering/referring provider and the ordering/referring provider is not in the claim, the claim will not be paid. It will be rejected. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **Effective January 3, 2011, if the ordering/referring provider is not in PECOS, the carrier or Part B MAC will search its claims system for the ordering/referring provider. If the ordering/referring provider is not in PECOS and is not in the claims system, the claim will not be paid. It will be rejected. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.**

- In **both phases**, Medicare will verify the NPI and the name of the ordering/referring provider reported in the claim against PECOS or, if the ordering/referring provider is not in PECOS, against the claims system. In paper claims, be sure not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.

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

PLEASE NOTE: The changes being implemented with CR 6417 do not alter any existing regulatory restrictions that may exist with respect to the types of items or services for which some of the provider types listed above can order or refer or any claims edits that may be in place with respect to those restrictions. Please refer to the Background Section, below, for more details.

Additional Information
You can find the official instruction, CR6417, issued to your carrier or B MAC by visiting **http://www.cms.gov/Transmittals/downloads/R642OTN.pdf** on the CMS website.

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

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

MLN Matters Number: MM6421 Revised
Related CR Release Date: February 26, 2010

Related CR Transmittal #: R643OTN

Related Change Request (CR) #: 6421
Effective Dates: Phase 1 - October 1, 2009
Phase 2 - January 1, 2011
Implementation Date: Phase 1 - October 5, 2009
Phase 2 - January 3, 2011

NOTE: *This article was revised on March 30, 2010, to reflect the changes in the release of a new CR on February 26, 2010. The implementation date and effective dates of Phase 2 are changed (see page 3, third bullet). The Transmittal number, CR release date and Web address for accessing the CR has also been changed. All other information remains the same.*

However, it is extremely important to read MLN Matters® Special Edition article, SE1011, at http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf to see important clarifying information regarding this issue.

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

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

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

The providers who can order/refer are:

- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;

- Optometry;
- Chiropractic Medicine;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker.

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

Key Points

- **During Phase 1 (October 5, 2009- January 2, 2011):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will continue to process.**
    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.**
    2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.**

- **During Phase 2, (January 3, 2011 and thereafter):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.**
    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.**
    2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.**

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

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

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

Additional Information

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

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R643OTN.pdf** on the CMS website.

Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (MM6566) (GEN)

MLN Matters® Number: MM6566
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R710OTN
Related Change Request (CR) #: 6566
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: *This article was revised on May 24, 2010, to reflect changes made to CR 6566 on May 21, 2010. The CR release date, transmittal number, and the Web address for accessing CR 6566 were changed. All other information is the same.*

Provider Types Affected
This article is for suppliers who submit claims to Medicare DME Medicare Administrative Contractors (DME MACs) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6566. The Centers for Medicare & Medicaid Services (CMS) is issuing CR6566 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 automatically denied 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 that "other persons" 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.

Key Points of CR6566

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 6, 2010, 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.

Take Note: Products and services requiring accreditation found on CMS 855S, Section 2D next to the NSC-MAC product codes along with HCPCS codes are as follows:

(To review the descriptors that accompany the HCPCS codes in the product categories see **Attachment C of CR6566**. The Web address of CR6566 can be found in the *Additional Information* section of this article.)

NSC-MAC Product Code	Product Category	HCPCS codes
DM06	Blood Glucose Monitors and Supplies (mail order)	A4253, A4259, A4256, A4258, A4235, A4233, A4234, A4236
M01	Canes and Crutches	A4636
R01	Continuous Positive Airway Pressure (CPAP) Devices	E0601, A7034, E0562, A7030, A7037, A7035, A7032, A7038, A7033, A7031, A7039, A7046, A7036, E0561, A4604, A7044, A7045
PE01	Enteral Nutrients, Equipment and Supplies	B4035, B4154, B4150, B4152, B4034, B9002, B4153, B4036, B4155, B4149, B9000, B4082, B4081, B4083, B4087, B4088
DM09	Hospital Beds - Electric	E0260, E0261, E0265, E0294, E0295, E0266, E0296, E0297
DM10	Hospital Beds - Manual	E0303, E0255, E0910, E0250, E0940, E0271, E0304, E0301, E0912, E0272, E0302, E0310, E0256, E0911, E0316, E0305, E0292, E0251, E0290, E0293, E0300, E0280, E0291
R08	Oxygen Equipment and Supplies	E1390, E0431, E0439, E0434, K0738, E1392, E0424, E0443, E1391, E0442, E0441, E0443, E0444
R09	Respiratory Assist Devices	E0470, E0471, E0472
DM20	Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads	E0277, E0372, E0373, E0371, E0193

NSC-MAC Product Code	Product Category	HCPCS codes
M05	Walkers	E0143, E0135, E0156, E0149, E0154, E0141, E0147, E0155, E0148, E0140, E0144, E0130, E0158, E0159, E0157, A4637
M09 M09A	Wheelchairs - Complete Rehabilitative Power Wheelchairs Wheelchairs - Complete Rehabilitative Power Wheelchair Related Accessories	K0835, K0836, K0841, K0838, K0837, K0842, K0843, K0839, K0840
M07 M07A	Wheelchairs - Standard Power Wheelchairs - Standard Power Related Accessories	K0823, K0822, K0825, K0800, K0824, K0814, K0821, K0801, K0816, K0827, K0815, K0826, K0813, K0806, K0807, K0828, K0802, K0829, K0820, K0808

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 website.

The official instruction (CR6566) issued to your Medicare DME MAC is available at **http://www.cms.gov/Transmittals/downloads/R710OTN.pdf** on the CMS website.

For additional information about the NSC-MAC and Recent Regulatory Revisions Pertinent to Suppliers of DMEPOS, see MLN Matters® article MM6282, which is available at **http://www.cms.gov/mlnmattersarticles/downloads/MM6282.pdf** on the CMS website.

July 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6805) (DRU)

MLN Matters® Number: MM6805
Related CR Release Date: February 19, 2010
Related CR Transmittal #: R1922CP
Related Change Request (CR) #: 6805
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected
All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) are affected by this issue.

What You Need to Know
This article is based on Change Request (CR) 6805 which instructs Medicare contractors to download and implement the July 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised April 2010, January 2010, October 2009, and July 2009 files. Medicare will use the July 2010 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 6, 2010, with dates of service July 1, 2010, through September 30, 2010.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

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

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 website. The official instruction (CR6805) issued to your Medicare MAC, carrier, and/or FI may be found at **http://www.cms.gov/Transmittals/downloads/R1922CP.pdf** on the CMS website.

July Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM6945) (GEN)

MLN Matters® Number: MM6945
Related CR Release Date: May 7, 2010
Related CR Transmittal #: R1967CP
Related Change Request (CR) #: 6945
Effective Date: January 1, 2010 for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010 for the revisions to the RA & RB modifier descriptors which became effective April 1, 2010; July 1, 2010 for all other changes
Implementation Date: July 6, 2010

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

Provider Action Needed
This article is based on Change Request (CR) 6945 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background
The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

Key Points of CR6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes with A4336, E1036, L8031, L8032, L8629 and Q0506 with dates of service on or after January 1, 2010 that have already been processed will not be adjusted to reflect the newly established fees if they are resubmitted for adjustment.

- CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code - A4221 Supplies for Maintenance of Drug Infusion Catheter, Per Week. To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.

- CR6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items. Additionally, the descriptors for RA and RB are being revised, effective April 1, 2010, to read as follows:
  - RA- Replacement of a DME, Orthotic or Prosthetic Item
  - RB- Replacement of a Part of a DME, Orthotic or Prosthetic Item Furnished as Part of a Repair

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

- Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is 5 years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than 5 years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than 5 years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to 3 months.

- HCPCS code Q0506 Battery, Lithium-Ion, For Use With Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than lithium ion - HCPCS codes Q0496 and Q0503 - remains at 6 months as described in CR3931, Transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA (Replacement of a DME, Orthotic or Prosthetic Item) to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

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 website.

The official instruction (CR6945) issued to your Medicare DME MAC may be found at **http://www.cms.gov/Transmittals/downloads/R1967CP.pdf** on the CMS website.

Medicare Coverage of Blood Glucose Monitors and Testing Supplies (SE1008) (SPE)

MLN Matters® Number: SE1008 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 re-issued on May 5, 2010, to include additional information regarding special blood glucose monitors for patients with manual dexterity issues, and to clarify certain information regarding the content of orders and when new orders are needed.*

Provider Types Affected
This article is informational for 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 Medicare covered diabetes benefits provided to Medicare beneficiaries.

What You Need to Know
This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to remind providers what blood glucose self-testing equipment and supplies are covered for Medicare beneficiaries. In addition, prescription/order requirements, quantities and frequency limits of supplies, and documentation requirements for the beneficiary's medical record are detailed. This article reinforces information supplied in MLN Matters® article SE0738, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE0738.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. **This article is informational only and represents no Medicare policy changes.**

Background
Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies. Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin dependent diabetics based on medical necessity. For more information regarding medical necessity, see the section below titled 'Providing Evidence of Medical Necessity.'

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions;
- A 2 hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

See the *Medicare Benefit Policy Manual*, Chapter 15, at **http://www.cms.gov/manuals/Downloads/bp102c15.pdf** on the CMS website for more information.

Coverage for diabetes-related Durable Medical Equipment (DME) is provided as a Medicare Part B benefit, and the Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

Prescribing/Ordering a Blood Glucose Monitor and Associated Accessories
Provider Requirements
For Medicare coverage of a blood glucose monitor and associated accessories, the provider must provide a valid prescription (order) which must state to the supplier:

1. The item(s) to be dispensed;
2. The frequency of testing ("as needed" is not acceptable);

3. The physician's signature;
4. The signature date; and
5. The start date of the order - only required if the start date is different than the signature date.

For beneficiaries who are insulin-dependent, Medicare provides coverage for up to 100 test strips and lancets every month, and one lancet device every 6 months.

For beneficiaries who are non-insulin dependent, Medicare provides coverage for up to 100 test strips and lancets every 3 months, and one lancet device every 6 months.

Note: Medicare allows additional test strips and lancets **if deemed medically necessary**. See the section below titled 'Providing Evidence of Medical Necessity.' Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers, even if the beneficiary has "authorized" this in advance. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the item(s) no sooner than approximately five (5) days prior to the end of usage for the current product(s). This includes lancets, test strips, and blood glucose monitors.

CR 2363 (Transmittal B-03-004) states that glucose test strips and supplies can be billed for up to 3 months of supplies at a time. Beginning April 1, 2002, claims for test strips and supplies must be submitted with the appropriate "start" and "end" dates. The "start" and "end" dates for each claim can span across 3 months. You can find CR 2363 at **http://www.cms.gov/Transmittals/Downloads/B03004.pdf** on the CMS website.

Suppliers may dispense most items of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) based on a verbal order or preliminary written order from the treating physician. This dispensing order must include: a description of the item, the beneficiary's name, the physician's name and the start date of the order. Suppliers must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available to Medicare contractors upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is non-covered. See the *Medicare Program Integrity Manual*, Chapter 5, at **http://www.cms.gov/manuals/downloads/pim83c05.pdf** on the CMS website.

For verbal orders, the physician must sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation must be reviewed, signed, and dated by the physician. Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing or a change in supplier. Renewal orders must contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC. For more information regarding evidence of medical necessity, see the section below titled 'Providing Evidence of Medical Necessity."

Note: CR 5971 (Transmittal 248) was issued to prohibit the use of stamped signatures. In addition, Medicare requires a legible identifier for services provided/ordered as outlined in CR 6698 (Transmittal R327PI). The method used should be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. You can review MLN Matters® articles related to CR 5971 and CR 6698 at **http://www.cms.gov/MLNMattersArticles/downloads/MM5971.pdf** and **http://www.cms.gov/mlnmattersarticles/downloads/mm6698.pdf** on the CMS website.

Home Blood Glucose Monitors

There are several different types of blood glucose monitors that use reflectance meters to determine blood glucose levels. Medicare coverage of these devices varies, with respect to both the type of device and the medical condition of the patient for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as DME for use in the home because their need for frequent professional re-calibration makes them unsuitable for home use.

However, some types of blood glucose monitors which use a reflectance meter specifically designed for home use by diabetic patients may be covered as DME, subject to the conditions and limitations described below.

Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and (following instructions which may vary with the device used), inserts it into the device to obtain a reading.

Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated.

Home blood glucose monitors enable certain patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment. Studies indicate that the patient's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to patients who must make frequent checks of their blood glucose levels.

Accordingly, coverage of home blood glucose monitors is limited to patients meeting the following conditions:

1. The patient has been diagnosed as having diabetes;
2. The patient's physician states that the patient is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician; and
3. The device is designed for home use rather than clinical use.

There are also blood glucose monitoring systems designed especially for use by those with visual or manual dexterity impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable patients with visual or manual dexterity impairment to use the equipment without assistance.

These special blood glucose monitoring systems are covered under Medicare if the following conditions are met:

- The patient and device meet the three conditions listed above for coverage of standard home blood glucose monitors; and
- The patient's physician certifies that the beneficiary has a visual or manual dexterity impairment severe enough to require use of this special monitoring system. Note: 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…" See **http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm** on the Internet.

For more information on home blood glucose monitors, including additional requirements for monitors with special features, see the *Medicare National Coverage Determinations Manual*, Chapter 1, Part 1 (Coverage Determinations), Section 40.2 (Home Blood Glucose Monitors) at **http://www.cms.gov/manuals/downloads/ncd103c1_Part1.pdf** on the CMS website and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at **http://www.cms.gov/mcd/search.asp?from2=search.asp&** (search "Glucose Monitors").

The Health Care Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are shown in the following table:

HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies

HCPCS Code	HCPCS Code Descriptor
A4233	Alkaline battery for glucose monitor
A4234	J-cell battery for glucose monitor
A4235	Lithium battery for glucose monitor
A4236	Silver oxide battery glucose monitor
A4253	50 test strips for a blood glucose monitor
A4256	Calibration solutions
A4258	Spring-powered lancing device

HCPCS Code	HCPCS Code Descriptor
A4259	100 lancets for a blood glucose monitor
E0607	Home blood glucose monitor
E2100	Home blood glucose monitor w voice capability (for visual impairment)
E2101	Home blood glucose monitor w integrated lancing/blood collection (for manual dexterity impairment)

Providing Evidence of Medical Necessity

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
  - Justification for testing frequency; and
  - Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
  - Names, dosages, and timing of administration of medications used to treat the diabetes;
  - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
  - Review of beneficiary-maintained log of glucose testing values;
  - Changes in the patient's treatment regimen as a result of glucose testing results review;
  - Dosage adjustments that the patient should make on their own based on self-testing results;
  - Laboratory tests indicating level of glycemic control (e.g., Hemoglobin A1C);
  - Other therapeutic interventions and results;
- Documentation by the beneficiary of the actual frequency of testing.
  - Logs of self-testing values including the date, time, and results
  - Information about medication dosage adjustments related to the results is also helpful.

Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

For more information regarding evidence of medical necessity, see the *Medicare Program Integrity Manual*, Chapter 5 (Items and Services Having Special DME Review Considerations) at **http://www.cms.gov/manuals/downloads/pim83c05.pdf** on the CMS website, and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at **http://www.cms.gov/mcd/search.asp?from2=search.asp&** (search "Glucose Monitors").

Additional Information

You can find SE0738, An Overview of Medicare Covered Diabetes Supplies and Services at **http://www.cms.gov/MLNMattersArticles/downloads/SE0738.pdf** on the CMS website.

You can also find The Guide to Medicare Preventive Services at **http://www.cms.gov/MLNProducts/downloads/mps_guide_Web-061305.pdf** and the Medicare Preventive Services Brochure at **http://www.cms.gov/MLNProducts/downloads/DiabetesSvcs.pdf** on the CMS website.

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 website.

Payment of Oxygen Contents to Suppliers after the 36th Month Rental Cap under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (MM6939) (OXY)

MLN Matters® Number: MM6939
Related CR Release Date: April 27, 2010
Related CR Transmittal #: R676OTN

Related Change Request (CR) #: 6939
Effective Date: October 1, 2010 for Medicare system changes
Implementation Date: October 4, 2010

Provider Types Affected
This article is for suppliers who have received payment for the 36th continuous use of oxygen equipment for a Medicare patient and billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen contents used with that liquid or gaseous oxygen equipment (stationary or portable).

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6939 to alert suppliers that Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment for any period of medical need after the payment cap for the remainder of the reasonable useful lifetime of the equipment. This requirement continues to apply under the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a competitive bidding area (CBA)). See the *Key Points* section of this article for more of the specifics of CR6939.

Background
On July 15, 2008, section 144(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(a)(5)(F) of the Social Security Act (the Act) to repeal the transfer of ownership provision established by the Deficit Reduction Act of 2005 for oxygen equipment and establish new payment rules and supplier responsibilities after the 36 month payment cap. One of the MIPPA 144(b) provisions requires that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. As further defined in Federal Regulations (42 CFR 414.226(f)(2)), **the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period of medical need for the remainder of the reasonable useful lifetime established for the equipment. If a beneficiary relocates, the supplier that received the payment for the 36th continuous month must arrange for furnishing the oxygen contents with another supplier if the beneficiary relocates to an area that is outside the normal service area of the supplier.** This MIPPA requirement for the supplier that received the 36th month payment to continue furnishing oxygen contents during any period of medical need for the remainder of the reasonable useful lifetime remains in effect regardless of whether the beneficiary resides in a CBA or the oxygen supplier is a contract, non-contract or grandfathered supplier under the DMEPOS competitive bidding program.

Key Points of CR6939

- If a beneficiary travels or temporarily relocates to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.

- The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.

- The changes specified in this CR6939 are in preparation for the DMEPOS Competitive Bidding Program Round One Rebid (the Round One Rebid) implementation. The target implementation date for the Round One Rebid is January 1, 2011 and is subject to change. CMS will send notification of the actual start date for the Round One Rebid in a separate instruction.

- **Remember** claims will be denied for both base oxygen equipment and related oxygen contents claims from non-contract suppliers in CBAs when the initial date on the beneficiary's oxygen Certificate of Medical Necessity (CMN) is on or after the start date for the Round One Rebid. Medicare will also deny such claims from non-contract suppliers when the rental period for the base oxygen equipment began on or after the start date of the Round One Rebid.

- **NOTE:** CR6939 provides instructions for processing oxygen contents claims received from a supplier when the beneficiary resides in a CBA and the 36-month payment cap has been reached for the related base equipment. The CR6939 does not address situations in which a beneficiary travels or temporarily relocates to a CBA. Moreover, it does not address the oxygen claim payment policies applicable to beneficiaries who do not reside in a CBA. The claims processing instructions related to these policies will be provided in a subsequent CR.

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 website.

The official instruction associated with this CR6939 issued to your Medicare MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R676OTN.pdf** on the CMS website.

To review the CMS DME website 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 website.

Quarterly Healthcare Common Procedure Coding System (HCPCS) Code Changes - July 2010 Update (MM6809) (GEN)

MLN Matters® Number: MM6809 Revised
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R1972CP
Related Change Request (CR) #: 6809
Effective Date: July 1, 2010 unless otherwise specified
Implementation Date: July 6, 2010

Note: *This article was revised on May 27, 2010, to correct the long description for HCPCS Code Q2025 on page 2. The description was corrected to show 1mg. Also, reference to code WW141 was deleted. All other information is the same.*

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 based on Change Request (CR) 6809 which provides the Quarterly Healthcare Common Procedure Coding System (HCPCS) Code changes for the July 2010 Update. Be sure your billing staff know of these HCPCS code changes as noted below.

Background
The HCPCS code set is updated on a quarterly basis. Change Request (CR) 6809 describes the process for updating these specific HCPCS codes.

Effective for claims with dates of service on or after July 1, 2010, the following HCPCS code will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2025	Oral fludarabine phosphate	Fludarabine phosphate, oral, 1mg	E

Note that suppliers are currently instructed to bill oral anti-cancer drugs to the DME MACs using the appropriate National Drug Code (NDC).

In addition, the Centers for Medicare & Medicaid Services (CMS) recently concluded that Dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration for this purpose, and then only in HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. Consequently, effective for claims with dates of service on or after March 23, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2026	Radiesse injection	Injection, Radiesse, 0.1ml	E
Q2027	Sculptra Injection	Injection, Sculptra, 0.1ml	E

Additional Information
Medicare contractors will not search their files to reprocess claims already processed, but will adjust such claims that you bring to their attention. The official instruction, CR 6809, 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/R1972CP.pdf** on the CMS website. 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 website.

Updated Form CMS-1500 Information (MM6929) (GEN)

MLN Matters® Number: MM6929
Related CR Release Date: May 21, 2010
Related CR Transmittal #: R1970CP
Related Change Request (CR) #: 6929
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected
This is an informational article for physicians, providers and suppliers who use Form CMS-1500 to submit claims to Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment (DME) MACs) for services provided to Medicare beneficiaries.

What You Need to Know
This article, based on Change Request (CR) 6929, updates Form CMS-1500 information in the *Medicare Claims Processing Manual* by removing language allowing the use of legacy identifiers and making other technical corrections as a result of that change. As part of this update, providers are reminded that they are responsible for purchasing their own CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as the forms follow the specifications approved by the Centers for Medicare & Medicaid Services as developed by the American Medical Association. Photocopies of the Form CMS-1500 are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. You may purchase forms from the U.S. Government Printing Office by calling 1-202-512-1800.

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

The official instruction issued to your Medicare carrier and/or MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R1970CP.pdf** on the CMS website.

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:

- **There are no updates to the 2nd Quarter 2010 Jurisdiction A DME MAC Fee Schedule**
- 2nd Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2010 Oral Anticancer Drug Fees

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

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

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

Change in the Amount in Controversy (AIC) Requirement for Administrative Law Judge Hearings and Federal District Court Appeals (MM6894) (GEN)

MLN Matters® Number: MM6894
Related CR Release Date: May 7, 2010
Related CR Transmittal #: R1965CP

Related Change Request (CR) #: 6894
Effective Date: August 9, 2010
Implementation Date: August 9, 2010

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

Provider Action Needed
This article is based on Change Request (CR) 6894, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2010.

- The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2010, is $120. **The amount remaining in controversy requirement for requests made on or after January 1, 2010, is $130.**

- **For Federal District Court review, the amount remaining in controversy goes** from $1,220 for requests on or after January 1, 2009, **to $1,260 for requests on or after January 1, 2010.**

Please ensure that your staff knows of these changes.

Background
The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6894 modifies the *Medicare Claims Processing Manual*, Chapter 29, Sections 220, 330.1, and 345.1 to update the AIC required for an ALJ hearing or judicial court review. CR 6894 also expands the background information in the Amount in Controversy General Requirements, Principles for Determining Amount in Controversy, and Aggregation of Claims to meet Amount in Controversy sections 250, 250.1, 250.2 and 250.3 in the *Claims Processing Manual*, Chapter 29. The revised portions of the manual are attached to CR 6894.

Additional Information
The official instruction (CR 6894) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at **http://www.cms.gov/Transmittals/downloads/R1965CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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 website.

A brochure entitled, *The Medicare Appeals Process: Five Levels To Protect Providers, Physicians And Other Suppliers*, provides an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process. The brochure is available at **http://www.cms.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf** on the CMS website.

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.

Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity Exclusion. CR6880 rescinds and fully replaces CR 6544. (MM6880) (GEN)

MLN Matters® Number: MM6880
Related CR Release Date: April 9, 2010
Related CR Transmittal #: R1944CP and R122BP

Related Change Request (CR) #: 6880
Effective Date: July 9, 2010
Implementation Date: July 9, 2010

Provider Types Affected
This article applies to 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 in State or local penal custody.

What You Need to Know
This article is based on Change Request (CR) 6880 which updates billing instructions and claims processing requirements to fully implement the policy for Medicare beneficiaries in State or local custody that was outlined in CR 6544. CR 6880 rescinds and fully replaces CR 6544, and revises the *Medicare Claims Processing Manual*, Chapter 1, Section 10.4 and the *Medicare Benefit Policy Manual*, Chapter 17, Section 50.3.3(3). These revisions are included as attachments to CR 6880.

Background
The Medicare program does not pay for services if:

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

Also, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services. See the Social Security Act Section 1862 (a)(2)&(3) at **http://www.socialsecurity.gov/OP_Home/ssact/title18/1862.htm** on the Internet.

In the Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule (72 FR 47409 and 47410; see **http://edocket.access.gpo.gov/2007/pdf/07-3820.pdf** on the Internet), the Centers for Medicare & Medicaid Services (CMS) clarified its regulations at 42 CFR 411.4(b)
(see **http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr411_main_02.tpl** on the Internet) by stating that for purposes of Medicare payment, **individuals who are in "custody" include**, but are not limited to, individuals who are:

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

42 CFR 411.4(b) describes the special conditions that must be met in order for Medicare to make payment for individuals who are in custody and states:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and

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

NOTE: Your Medicare contractor will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources. In addition, the State or local entity must document its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, your Medicare contractor will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the State or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

The Centers for Medicare & Medicaid Services (CMS) maintains a file of incarcerated beneficiaries, obtained from the Social Security Administration (SSA) that is used to edit claims.

To avoid improper denial of claims, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above should indicate this fact with the use of a the QJ modifier on claims for such services.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals should identify the incarceration period by billing as non-covered all days, services and charges that overlap the incarceration period.

Additional Information
The official instruction, CR 6880, was issued to your carrier, FI, A/B MAC, and DME MAC in two transmittals. The first transmittal modifies the *Medicare Claims Processing Manual* and it is available at **http://www.cms.gov/Transmittals/downloads/R1944CP.pdf** on the CMS website. The second transmittal is at **http://www.cms.gov/Transmittals/downloads/R122BP.pdf** and it contains the revised portion of the *Medicare Benefit Policy Manual* regarding this change.

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 website.

Clinical Review Judgment (MM6954) (GEN)

MLN Matters® Number: MM6954
Related CR Release Date: May 14, 2010
Related CR Transmittal #: R338PI

Related Change Request (CR) #: 6954
Effective Date: April 23, 2010
Implementation Date: June 15, 2010

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

What You Need to Know
CR 6954, from which this article is taken:

- Adds Section 3.14 (Clinical Review Judgment) to the *Medicare Program Integrity Manual*, clarifying existing language regarding clinical review judgments; and
- Requires that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Background
Medicare claim review contractors (Carriers, Fiscal Intermediaries (called affiliated contractors, or ACs), Medicare Administrative Contractor (MACs), the Comprehensive Error Rate Testing (CERT) contractor, and Recovery Audit Contractors (RACs)), along with

Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC) are tasked with measuring, detecting and correcting improper payments in the Fee for Service (FFS) Medicare Program.

CR 6954, from which this article is taken, updates the *Medicare Program Integrity Manual* by adding a new Section (3.14 - Clinical Review Judgment) which clarifies existing language regarding clinical review judgments; and also requires that Medicare claim review contractors instruct their clinical review staffs to use the clinical review judgment process when making complex review determinations about a claim.

This clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

NOTE: *Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).*

Additional Information
You can find more information about clinical review judgment by going to CR 6954, located at **http://www.cms.gov/Transmittals/downloads/R338PI.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section14 (Clinical Review Judgment) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, RHHI, 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 website.

Durable Medical Equipment National Competitive Bidding Implementation – Phase 10C: Exception for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan (MM6918) (GEN)

MLN Matters® Number: MM6918
Related CR Release Date: April 30, 2010
Related CR Transmittal #: R690OTN
Related Change Request (CR) #: 6918
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected
Suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries are impacted by this issue.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6918 to alert providers that under certain circumstances Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) payment will be allowed for grandfathered items for beneficiaries who received services from a DMEPOS supplier while under a Medicare Advantage plan. Those items should be furnished by a non-contract Medicare Advantage (MA) supplier under the DMEPOS Competitive Bidding Program for a beneficiary who resides in a competitive bidding area (CBA) and elects to leave their MA plan or loses his/her coverage under this plan. Such beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program.

However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier; meet the Medicare fee for service (FFS) coverage criteria and documentation requirements; and elect to become a grandfathered supplier.

Key Points of CR6918

- Medicare will pay claims that qualify for the MA plan grandfathering exception at the Round One bid amount during the Round One contract period. The target implementation date for the Round One Rebid is January 1, 2011, and is subject to change.
- The beneficiary must have been enrolled in a MA plan on the day prior to the start date for the Round One Rebid to qualify for the MA plan grandfathering exception.

Background

The Medicare DMEPOS Competitive Bidding Program was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) which amended section 1847 of the Social Security Act (the Act) to require the Secretary of Health and Human Services 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 Medicare Part B.

Section 1847(a)(4) requires that in the case of covered DME items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary must establish a "grandfathering" process by which rental agreements for the DME covered items and oxygen are entered into before the start of the competitive bidding program may be continued.

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 website. The official instruction associated with this CR6918, issued to your Medicare DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R690OTN.pdf** on the CMS website.

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

Enhancements to Home Health (HH) Consolidated Billing Enforcement (MM6911) (GEN)

MLN Matters® Number: MM6911
Related CR Release Date: April 28, 2010
Related CR Transmittal #: R1952CP

Related Change Request (CR) #: 6911
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

What You Need to Know

Consolidated Billing Edit Modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, chapter 10, section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing

falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item 'from' or 'to' date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the 'from' date and the date by which the supplies will be used in the 'to' date. When this causes the 'to' date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the 'from' date on the supply line item falls within a HH episode.

A New File of HH Certification Information

Chapter 10, section 20.1 of the *Medicare Claims Processing Manual* describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

- G0179 Physician Re-certification For Medicare-covered Home Health Services Under A Plan of Care
- G0180 Physician Certification For Medicare-covered Home Health Services Under A Plan of Care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60% or 50% payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's Common Working File (CWF) query screens, Medicare systems will display all certification code dates within 9 months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within 9 months before the current date as the default response.

NOTE: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particular true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40% of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Additional Information

If you have questions, please contact your Medicare RHHI/MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction (CR6911) issued to your Medicare RHHI/MAC is available at **http://www.cms.gov/Transmittals/downloads/R1952CP.pdf** on the CMS website.

Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Version 005010 Medicare Administrative Contractors Requirements (MM6472) (GEN)

MLN Matters® Number: MM6472
Related CR Release Date: June 19, 2009
Related CR Transmittal #: R506OTN

Related Change Request (CR) #: 6472
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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

Provider Action Needed
This article is informational only for providers. It is based on Change Request (CR) 6472 which provides Medicare Administrative Contractors (MACs), and DME MACs, and the DME MACs Common Electronic Data Interchange (CEDI) Contractor with requirements to prepare their systems to process ASC X12 (also known as ANSI ASC X12) version 005010 (both A/B and DME MACs) transactions and National Council for Prescription Drug Programs (NCPDP) version D.0 (only DME) transactions. While CR 6472 requires no action for providers, you may want to review MLN Matters® article SE0904, at **http://www.cms.gov/MLNMattersArticles/downloads/SE0904.pdf**, for an introductory overview of these HIPAA standards.

Background
The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 as the next Health Insurance Portability and Accountability Act (HIPAA) transaction standards for covered entities to exchange HIPAA transactions. The DHHS published the final rule on January 16, 2009, which can be reviewed at **http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf** on the Internet. The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing this next version of HIPAA transaction standards.

The purpose of Change Request 6472 is to provide the MACs and the DME MACs Common Electronic Data Interchange (CEDI) Contractor with the necessary requirements to prepare their systems to process ASC X12 version 005010 (both A/B and DME MACs) and NCPDP version D.0 (only DME) transactions.

Note: The DHHS has promulgated in the Final Rules provisions which permit dual use of existing standards [*ASC X12 4010A1 and NCPDP 5.1*] and the new standards [*ASC X12 version 5010 and NCPDP version D.0*] from March 17, 2009 (the effective date) until January 1, 2012 (the compliance date) to facilitate testing (subject to trading partner agreement).

Additional Information
The official instruction, CR 6472, issued to your MAC or DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R506OTN.pdf** on the CMS website.

If you have any questions, please contact your 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 website.

Implementation of the new Health Insurance Portability and Accountability Act Formats for all Durable Medical Equipment Medicare Administrative Contractor Electronic Trading Partners (GEN)

Are you prepared for the conversion to the new Health Insurance Portability and Accountability Act (HIPAA) formats? Will your software be ready in time? The Centers for Medicare & Medicaid Services (CMS) has mandated the industry upgrade to X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 (the NCPDP D.0 format is used by retail pharmacies) by January 1, 2012. Even though this deadline seems far away, now is the time to start preparing for these changes.

The Common Electronic Data Interchange (CEDI) will be fully compliant with ANSI X12 version 5010 and NCPDP version D.0 code sets according to the timelines established by the U.S. Department of Health and Human Services (HHS).

Timelines

January 1, 2011	The Common Electronic Data Interchange (CEDI) will open testing of the new HIPAA formats to all software vendors or suppliers with proprietary systems. Once a software vendor is approved, they can begin moving their customers into production.
January 1, 2012	CEDI will only accept and return the new HIPAA formats (ANSI X12 5010 and NCPDP D.0). All DME MAC electronic trading partners must be in production with the new HIPAA formats by this date. **Note:** Electronic trading partners can move into production any time on or after January 1, 2011 as long as their software has been approved for the new HIPAA format(s) (ANSI X12 5010 and/or NCPDP D.0).

Front-end Reports

The current X12 version 4010A1 electronic claims front-end reports created and produced by the Common Electronic Data Interchange (CEDI) (997, TRN and GenResponse) will be replaced with the 999 and 277CA transactions once an electronic trading partner begins using the new X12 version 5010 format. The 999 and 277CA transactions will not be readable without translation, so suppliers will have to get these new reports read by their software. The 999 and 277CA transactions are not HIPAA mandated; however, CMS is requiring these transactions for all Medicare business. **Note:** The TA1 produced by CEDI and the Certificate of Medical Necessity (CMN) rejection report produced by the durable medical equipment Medicare administrative contractors (DME MACs) and delivered by CEDI will continue to be produced for X12 version 5010 transactions.

The current NCPDP version 5.1 front-end report created and produced by CEDI will be replaced with an NCPDP formatted transmission response report for NCPDP version D.0 claims. The version D.0 NCPDP transmission response report will not be readable without translation, so suppliers will need to have these reports read by their software.

PC-ACE Pro32 Users

The PC-ACE Pro32 software will be updated for the new HIPAA X12 version 5010 claims format and made available in 2011. CEDI will provide notification via the CEDI Listserv and Web site as soon as the X12 version 5010 of the PC-ACE Pro32 software is available.

Express Plus Users

The Common Electronic Data Interchange no longer supports the Express Plus software; therefore it will not be updated for the new HIPAA X12 version 5010 format. All suppliers using Express Plus should have converted to PC-ACE Pro32 or another software program as of April 1, 2010.

What You Need to Do

All DME MAC electronic trading partners need to make sure their software programs will be ready for the new X12 version 5010 and/or NCPDP version D.0 standards according to the timelines listed above. National Government Services CEDI suggests you contact your software vendor, billing service or clearinghouse to make sure they are aware of the changes to the new HIPAA formats.

A list of questions to ask your software vendor, billing service, or clearinghouse:

- Will you be upgrading my current system to accommodate the ANSI X12 5010 and/or NCPDP D.0 transactions?
- Does my contract include an update to the ANSI X12 5010 and/or NCPDP D.0 standards or will I be required to pay for this upgrade? If so, how much will it cost?
- When will my system be upgraded with the ANSI X12 5010 and/or NCPDP D.0 standards?
- When will the installation to my system be completed?
- Will I need to purchase any new hardware?
- Will you be increasing your fees to cover the cost of the ANSI X12 5010 and/or NCPDP D.0 implementation?
- Will you have any testing and validation phases with me directly so I can see if any problems occur when submitting claims?
- Who should I call if we have problems submitting claims with the ANSI X12 5010 and/or NCPDP D.0 formats?
- Will the ANSI X12 5010 upgrade include a way to translate the 277 claims acknowledgement (277CA) electronic transaction into a format to show me if there was an error in the claim?
- Will the ANSI X12 5010 upgrade include a way to translate the Functional Transaction 999 into a format to show me the file was accepted by the Medicare contractor?
- Will the NCPDP D.0 upgrade include a way to translate the NCPDP front-end transmission response report into a readable format to show me if the claim was accepted by the Medicare contractor or if there was an error on the claim?
- Will this require any additional training by my staff? If so, where can I obtain this training and will there be additional costs for this training?

Important: It is up to you as the health care provider to ensure your transactions are conducted in compliance with HIPAA regulations - whether or not you contract with a software vendor, billing services, or clearinghouse.

Additionally, The Administrative Simplification Compliance Act (ASCA) requires the use of electronic claims (except for certain rare exceptions) in order for suppliers to receive Medicare payment. Therefore, effective January 1, 2012, you must be ready to submit your claims electronically using the X12 version 5010 and/or NCPDP version D.0 standards.

Remember, the X12 version 5010 and version D.0 HIPAA standards are national standards and apply to your electronic transactions with all payers, not just with fee-for-service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well.

Additional Information/Resources
The Centers for Medicare & Medicaid Services has created an entire section of their Web site devoted to the new HIPAA formats, including a Medicare comparison of the current and new formats, at **http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp**

The Centers for Medicare & Medicaid Services Web site for industry-wide information, including upcoming free educational seminars is: **http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp**

Medicare Quality Standards and Beneficiary Protections for Respiratory Equipment, Power Mobility Devices, and Other Related Durable Medical Equipment (SE1009) (GEN)

MLN Matters® Number: SE1009
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 all suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for providing respiratory equipment, power mobility devices (PMD) and other related DME to Medicare beneficiaries.

What You Need to Know
This Special Edition article provides the Medicare quality standards for beneficiary protection and safeguard requirements related to respiratory therapy equipment , PMDs, and other related DME.

Background

Beneficiary Assurances

All Medicare billed durable medical equipment (DME) has beneficiary protections such as:

- The equipment that the beneficiary uses meets all manufacturer standards, is provided by trained professionals in the manner that is 1) nationally recognized for safe and effective patient care and that 2) meets their needs and therapeutic goals, and that they are provided education in order to minimize any hazard or safety risks;

- All personnel who are educating the beneficiary, or repairing their equipment, are working within the scope of their practice and their state requirements;

- Whenever the beneficiary needs assistance, someone with the right professional knowledge will be able to answer all of their questions or come out to their home, if necessary, to provide additional equipment or troubleshoot an issue with the existing equipment; and

- If there is an incident with their equipment, the supplier will be responsive in determining what caused the problem, in removing the problem and in assuring the beneficiary that the risk of the same issue occurring has been minimized.

In order to provide these beneficiary assurances, all suppliers that provide any DME to Medicare beneficiaries must:

- Provide only items that meet applicable Food and Drug Administration (FDA) regulations and medical device effectiveness and safety standards, and provide manufacturer copies of the features, warranties, and instructions for each type of non-custom fabricated item to the beneficiary;

- Have equipment delivery, set-up, and beneficiary education accomplished by competent technical and professional personnel who are licensed, certified, or registered, and who are functioning within their scope of practice as required by their State standards;

- Make repair and maintenance available on all equipment and item(s) provided;

- Provide regular business hour and after-hour access telephone number(s) for customer service, and for information about equipment repair, and emergency coverage;

- Implement a program that promotes the safe use of equipment, and minimizes safety risks, infections, and hazards; and

- Investigate any incident, injury, or infection in which DMEPOS may have been a contributor, when they become aware.

Beneficiary Safeguards

Medicare beneficiaries who use DME are assured that:

- They are made knowledgeable about the safe use and maintenance of their equipment;

- By complying with appropriate maintenance standards (such as not developing a secondary infection from respiratory equipment, by maintaining it according to OSHA standards), they will not acquire an equipment related complication;

- The equipment can be used wherever the beneficiary lives (at home or in various care facilities, such as an assisted care facility or a nursing home); and

- Their needs are consistently reevaluated by both the prescribing physician and the supplier to make certain that the equipment is being used appropriately and is meeting the intended therapeutic goals.

In order to provide these beneficiary safeguards, all suppliers that provide any DME to Medicare beneficiaries must:

- Provide the appropriate information about equipment set-up features, routine use, troubleshooting, cleaning, and maintenance;

- Provide education and any instructional material that is tailored to the beneficiary's particular needs, abilities, learning preferences, and language;

- Provide relevant information about infection control issues related to the use of all equipment and item(s) provided;
- Ensure that the beneficiary can use all equipment and item(s) provided safely and effectively in the settings of anticipated use; and
- Provide follow-up services to the beneficiary, consistent with the types of equipment provided, and recommendations from the prescribing physician.

Beneficiary Safeguards for Respiratory Equipment
Medicare beneficiaries who use respiratory equipment are assured that:

- When they need assistance, someone with the professional knowledge will be able to come out to their home, if necessary, to provide additional equipment or troubleshoot an issue with the existing equipment;
- All equipment is provided by trained professionals in the clinical manner that is nationally recognized for safe and effective patient care; and
- They receive, in accordance with the *American Association for Respiratory Care Practice Guidelines*, the proper education on the safe and effective use of their equipment and treatment modality.

NOTE: *Such standards ensure beneficiaries have the information they need to be an active participant in their care.*

In order to provide these beneficiary safeguards, all suppliers that provide any respiratory equipment to Medicare beneficiaries must:

- Provide respiratory services 24 hours a day, 7 days a week, as required;
- Comply with the current version of the *American Association for Respiratory Care Practice Guidelines for Oxygen Therapy in the Home or Extended Care Facility; Long Term Invasive Mechanical Ventilation in the Home; and Intermittent Positive Pressure Breathing (IPPB);* and
- Provide training to the beneficiary consistent with the current version of the *American Association for Respiratory Care (AARC) Practice Guidelines*.

NOTE: *AARC guidelines can be found at* ***http://www.rcjournal.com/cpgs/index.cfm*** *on the Internet.*

Beneficiary Safeguards for Any Power Mobility Devices (PMDs)
PMDs include power wheelchairs and power operated vehicles (POVs) and accessories. Complex Rehabilitative Wheelchairs are: 1) Group 2 power wheelchairs with power options; and 2) Group 3 and higher power and manual wheelchairs that can accommodate rehabilitative accessories and features, for example, tilt in space.

Medicare beneficiaries who use Manual wheelchairs, PMDs, and complex rehabilitative wheelchairs and assistive technology are assured that they receive the wheelchair that best meets their needs based on a complete physical and environmental assessment.

All suppliers that provide any Manual Wheelchairs, Power Mobility Devices (PMDs), and Complex Rehabilitative Wheelchairs and Assistive Technology must verify that seating, positioning and specialty assistive technology have been evaluated.

Beneficiary Safeguards for any Complex Rehabilitative Wheelchairs and Assistive Technology
Medicare beneficiaries who use complex rehabilitative wheelchairs and assistive technology are assured that:

- Anyone evaluating them has the training and experience to handle all of the technology and understands their very complex needs;
- Their privacy will be maintained, and that they will be treated with respect;
- The equipment they receive can always be repaired, modified, and maintained (one of the most important aspects of providing safe and therapeutic complex rehabilitation);
- Everyone associated with the equipment is always actively participating in assessing, and with providing the optimal care and equipment that they require;

- The equipment will be reliable and will work for the beneficiary without worry; and

- Beneficiaries receive the equipment at their convenience, in a prompt manner and according to both the prescribing physician's recommendations and the beneficiaries assessed needs.

All suppliers that provide any Complex Rehabilitative Wheelchairs and Assistive Technology must:

- At each of their locations, employ (as a W-2 employee) at least one qualified individual as a Rehabilitative Technology Supplier (RTS), who is either a Certified Rehabilitative Technology Supplier (CRTS); or an Assistive Technology Professional (ATP).

- Have at least one or more trained technicians available to service each location, who is identified by the following:
  - Factory trained by manufacturers of the products supplied by the company;
  - Experienced in the field of Rehabilitative Technology, (e.g., on the job training, familiarity with rehabilitative clients, products and services);
  - Completed at least 10 hours annually of continuing education specific to Rehabilitative Technology; and
  - Able to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.

- Provide the beneficiary private, clean, and safe rooms appropriate for fittings and evaluations;

- Maintain a repair shop located in the facility (or in close proximity, or easily accessible from another of the supplier's locations), as well as an area appropriate for product assembly and modification;

- Ensure that the RTS coordinates services with the prescribing physician to conduct face-to-face evaluations of the beneficiary in an appropriate setting and include input from other members of the health care team (i.e., Physical Therapist, Occupational Therapist, etc.);

- Provide the beneficiary with appropriate equipment for trial and simulation, when necessary.

- Implement procedures for assembly and set-up of equipment as well as a process to verify that the final product meets the specifications of the original product recommendation approved by the prescribing physician.

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

Reporting Changes in Surety Bonds (MM6854) (GEN)

MLN Matters® Number: MM6854
Related CR Release Date: March 26, 2010
Related CR Transmittal #: R332PI

Related Change Request (CR) #: 6854
Effective Date: June 28, 2010
Implementation Date: June 28, 2010

Provider Types Affected
Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) submitting claims to Medicare DME Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries are impacted by this issue.

Provider Action Needed
This article is based on Change Request (CR) 6854 which clarifies the situations in which certain DMEPOS surety bond changes must be reported to the National Supplier Clearinghouse (NSC). Be certain to comply with these changes.

Background
CR 6854 outlines scenarios in which suppliers of DMEPOS are required to report certain surety bond changes to the NSC.

A DMEPOS supplier must submit an addendum to the existing bond (or, if the supplier prefers, a new bond) to the NSC in the following instances: (1) a change in bond terms, (2) a change in the bond amount, or (3) a location on a bond covering multiple non-chain locations is being added or deleted.

In addition, pursuant to 42 CFR 424.57(d)(6)(iv), (at **http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr424.57.pdf** on the Internet) the surety must notify the NSC if there is a lapse in the surety's coverage of the DMEPOS supplier. This can be done via letter, fax, or e-mail to the NSC; the appropriate addresses can be found on the NSC's Web site at **NSC Contact Information** on the Internet.

Additional Information
If you have questions, please contact the NSC at (866) 238-9652 from 9 a.m. until 5 p.m. EST to reach a customer service representative. The official instruction, CR6854, issued to your Medicare MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R332PI.pdf** on the CMS website.

Medicare's surety bond requirements are summarized in detail in article MM6392 at **http://www.cms.gov/MLNMattersArticles/downloads/MM6392.pdf** on the CMS website.

To review 42 CFR 424.57 you may go to **http://edocket.access.gpo.gov/cfr_2002/octqtr/pdf/42cfr424.57.pdf** on the Internet.

Section 2902 of the Patient Protection and Affordable Care Act Permanently Extends Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 for the Payment of Indian Health Services (IHS) (SE0930) (DRU)

MLN Matters® Number: SE0930 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: January 1, 2010
Implementation Date: As soon as possible

Note: *This article was revised and re-issued on March 31, 2010, to reflect the impact of the Patient Protection and Affordable Care Act on these IHS services. In essence, the new Act permanently extends Section 630 of the MMA retroactive to January 1, 2010. See the rest of this article to see how the new law impacts your claims.*

Provider Types Affected
Indian Health Service (IHS) tribe and tribal organizations and facilities submitting claims to Medicare contractors

Provider Action Needed
This special edition article was initially issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that, per the provisions of section 630 of the MMA, certain Part B services were no longer covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, on March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. Section 2902 of the new law permanently extends Section 630 of the MMA, retroactive to January 1, 2010.

The services involved include the following:

- Durable Medical Equipment, prosthetics, and orthotics;
- Therapeutic shoes;
- Clinical laboratory services;
- Surgical dressings, splints and casts;
- Drugs (those processed by the J4 A/B Medicare Administrative Contractor (MAC) and the DME MACs);
- Ambulance services;

- Influenza and pneumonia vaccinations; and
- Screening and preventive services.

Indian Health Service providers, suppliers, physicians and other practitioners should contact their Medicare Contractor for further guidance regarding IHS claims affected by the new law, for dates of service January 1, 2010, and after, that were denied, prior to implementation of the new law.

Note: It will take approximately two weeks for your Medicare Contractor to update their systems to be able to pay correctly for these services. You may want to wait until the claims processing system is updated before submitting any new claims containing these IHS services. CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue.

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

Signature Guidelines for Medical Review Purposes (MM6698) (GEN)

MLN Matters® Number: MM6698 Revised
Related CR Release Date: March 16, 2010
Related CR Transmittal #: R327PI

Related Change Request (CR) #: 6698
Effective Date: March 1, 2010
Implementation Date: April 16, 2010

Note: *This article was revised and re-issued on April 26, 2010, to include additional clarifying language from CR 6698.*

Provider Types Affected
This article is for physicians, non-physician practitioners, and suppliers submitting claims to Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), Carriers, Regional Home Health Intermediaries (RHHIs), and/or Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued CR 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for E-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for reviews conducted on or after the implementation date of April 16, 2010. **Please note that all signature requirements in CR 6698 are effective retroactively for Comprehensive Error Rate Testing (CERT) for the November 2010 report period.**

Background
Those contractors who review Medicare claims include MACs, Affiliated Contractors (ACs), the CERT contractors, Recovery Audit Contractors (RACs), Program Safeguard Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Fee for Service (FFS) Medicare Program.

The previous language in the *Program Integrity Manual* (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds E-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the *Medicare Benefit Policy Manual*, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician

(e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g.MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:
If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.

- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.

- **Definition of a handwritten signature** is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.

- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered. **EXAMPLE:** The claim selected for review is for a hospital visit on October 4. The Additional Documentation Request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.

- **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.

- **Definition of an Attestation Statement:** In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.

- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

I, _____[print full name of the physician/practitioner]___, hereby attest that the medical record entry for _____[date of service]___ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.

- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.

- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.

- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.

- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
  - In the situations where the guidelines indicate "**signature requirements met**," the reviewer will consider the entry.
  - In situations where the guidelines indicate "**contact provider and ask a non-standard follow up question**," the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
  - In the situations where the guidelines indicate "**signature requirements NOT met**," the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified E-Prescribing system. For Medicare Part B medical review purposes, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, *42 CFR 423.160 Standards for Electronic Prescribing*, you may go to **http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf** on the Internet.

- When Part B drugs, other than controlled substances, have been ordered through a qualified E-Prescribing system, the reviewer will NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.

- At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall NOT accept as a valid order any controlled substance drugs that are ordered through any E-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.

- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare

medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified E-Prescribing system, the reviewer shall NOT require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

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

The official instruction, CR6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R327PI.pdf** on the CMS website.

Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months (MM6960) (GEN)

MLN Matters® Number: MM6960
Related CR Release Date: May 7, 2010
Related CR Transmittal #: R697OTN
Related Change Request (CR) #: 6960
Effective Date: January 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected
This issue impacts all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the timely filing limits for submitting claims for Medicare Fee-for-Service (FFS) reimbursement. As a result of the PPACA, claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare. Further details follow in this article. Make sure your billing staff is aware of these changes.

Background
Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act as well as the Code of Federal Regulations (CFR), 42 CFR Section 424.44 specify the timely filing limits for submitting claims for Medicare Fee-For-Service (FFS) reimbursement. Prior to PPACA, the regulations stated the service provider or supplier must submit claims for services furnished during the first nine (9) months of the calendar year on or before December 31st of the following calendar year. For services rendered during the last quarter of the calendar year, the provider or supplier must submit the claim on or before December 31st of the second following year.

Section 6404 of 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. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.

What You Need to Know
Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-PPACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline and;
- Claims with dates of service January 1, 2010 and later received more than 1 calendar year beyond the date of service will be denied as being past the timely filing deadline.

NOTE: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify exceptions to the one (1) calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR section 424.44(b)(1), for "error or misrepresentation" of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

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

The official instruction (CR6960) issued to your Medicare FI, Carrier, DME MAC, A/B MAC and/or RHHI is available at **http://www.cms.gov/Transmittals/downloads/R697OTN.pdf** on the CMS website.

CMS Manual System
Pub 100-20 One-Time Notification
Transmittal 652

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Date: March 17, 2010
Change Request 6712

Transmittal 617, dated January 8, 2010, is being rescinded and replaced with Transmittal 652, dated March 17, 2010. This change request (1) clarifies the reference to the manual section authorizing MUEs, and (2) clarifies the name of files for the final DME list of MUEs, and provides the denial reason code to be used for MUE denials.

SUBJECT: Medically Unlikely Edits (MUEs)

I. SUMMARY OF CHANGES: CMS developed the MUE program to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. Note that the MUE program provides a method to report medically reasonable and necessary UOS in excess of an MUE.

This CR provides updates and clarifications to MUE requirements established in 2006.

NEW / REVISED MATERIAL
EFFECTIVE DATE: APRIL 1, 2010
IMPLEMENTATION DATE: APRIL 5, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment - One-Time Notification

Pub. 100-20	**Transmittal: 652**	**Date: March 17, 2010**	**Change Request 6712**

Transmittal 617, dated January 8, 2010, is being rescinded and replaced with Transmittal 652, dated March 17, 2010. This change request (1) clarifies the reference to the manual section authorizing MUEs, and (2) clarifies the name of files for the final DME list of MUEs, and provides the denial reason code to be used for MUE denials.

SUBJECT: Medically Unlikely Edits (MUEs)

EFFECTIVE DATE: APRIL 1, 2010
IMPLEMENTATION DATE: APRIL 5, 2010

I. GENERAL INFORMATION:

A. Background: CMS developed the MUE program to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

As clarification, an MUE is a unit of service (UOS) edit for a HCPCS/CPT code for services that a single provider/supplier rendered to a single beneficiary on the same date of service. The ideal MUE is the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. Note that the MUE program provides a method to report medically likely UOS in excess of an MUE.

Further, all CMS claims processing contractors (including contractors using the Fiscal Intermediary Shared System (FISS)) shall adjudicate MUEs against each line of a claim rather than the entire claim. Thus, if a HCPCS/CPT code is changed on more than one line of a claim by using CPT modifiers, the claims processing system separately adjudicates each line with that code against the MUE.

In addition, fiscal intermediaries (FIs), carriers and Medicare Administrative Contractors (MACs) processing claims shall deny the entire claim line if the units of service on the claim line exceed the MUE for the HCPCS/CPT code on the claim line. Since claim lines are denied, the denial may be appealed.

Since each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of CPT modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE. CPT modifiers such as 76 (repeat procedure by same physician), 77 (repeat procedure by another physician), anatomic modifiers (e.g., RT, LT, F1, F2), 91 (repeat clinical diagnostic laboratory test), and 59 (distinct procedural service), will accomplish this purpose. Providers/suppliers should use Modifier 59 only if no other modifier describes the service.

On or about October 1, 2008, CMS announced that it would publish at the start of each calendar quarter the majority of active MUEs and post them on the MUE Webpage at "**http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage**."

Note that, at the onset of the MUE program, all MUE values were confidential, and for use only by CMS and CMS contractors. Since October 1, 2008, CMS has published most MUE values at the start of each calendar quarter. However, some MUE values are not published and continue to be confidential information for use by CMS and CMS contractors only. The confidential MUE values shall not be shared with providers/suppliers or other parties outside the CMS contractor's organization. The files referenced in the business requirements of this CR contain both published and unpublished MUE values. In the MUE files each HCPCS code has an associated "Publication Indicator". A Publication Indicator of "0" indicates that the MUE value for that code is confidential, is not in the CMS official publication of the MUE values, and should not be shared with providers/suppliers or other parties outside the CMS contractor's organization. A Publication Indicator of "1" indicates that the MUE value for that code is published and may be shared with other parties.

The full set of MUEs is available for the CMS contractors only via the Baltimore data center (BDC). A test file will be available about 2 months before the beginning of each quarter, and the final file will be available about 6 weeks before the beginning of each quarter. Note that MUE file updates are a full replacement. The MUE adds, deletes, and changes lists will be available about 5 weeks before the beginning of each quarter.

This CR provides updates and clarifications to MUE requirements established in 2006.

B. Policy: The NCCI contractor produces a table of MUEs. The table contains ASCII text and consists of six columns (Refer to Appendix 1 - Tabular Presentation of the Format for the MUE Transmission). There are three format charts, one for contractors using the Medicare Carrier System (MCS), one for contractors using the VIPS Medicare System (VMS) system, and one for the contractors using the FISS system.

Contractors shall apply MUEs to claims with a date of service on or after the beginning effective date of an edit and before or on the ending effective date.

Further, CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the value in column 2 of the MUE table. Pub. 100-08, PIM, chapter 3, section 3.5.1, indicates that automated review is acceptable for medically unlikely cases and apparent typographical errors.

The CMS will set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

Since claim lines are denied, denials may be appealed.

Appeals shall be submitted to local contractors not the MUE contractor, Correct Coding Solutions, LLC.
Note that, quarterly, the NCCI contractor will provide files to CMS with a revised table of MUEs and contractors will download via the Network Data Mover.

Furthermore, if Medicare contractors identify questions or concerns regarding the MUEs, they shall bring those concerns to the attention of the NCCI contractor. The NCCI contractor may refer those concerns to CMS, and CMS may act to change the MUE limits after reviewing the issues and/or upon reviewing data and information concerning MUE claim appeals.

Finally, a denial of services due to an MUE is a coding denial, not a medical necessity denial. A provider/supplier shall not issue an Advance Beneficiary Notice of Noncoverage (ABN) in connection with services denied due to an MUE and cannot bill the beneficiary for units of service denied based on an MUE.

The denied units of service shall be a provider/supplier liability.

The CMS will distribute the MUEs as a separate file for each shared system when the quarterly NCCI edits are distributed.

II. BUSINESS REQUIREMENTS

Number	Requirement	Responsibility(place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIERS	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6712.1	The shared systems maintainers shall develop a line level edit to deny the entire line on the claim when the units of service are in excess of the MUE value. FISS is not checked because FISS provides the capability for contractors to return the claim to the provider (RTP) or deny the line item that contain units that exceed the MUE. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.	X		X	X						
6712.1.1	Since contractors that use the FISS have the ability to either return the claim to the provider or deny the claim line, those contractors shall deny the line item.	X		X							
6712.1.2	Currently Part A contractors RTP claims that hit the MUE edit (reason code 31715). BR 6712.1, will deny the lines of service based on MUE table and the claim dates of service effective 040110. The current MUE edit (reason code 31715) shall have a term date of March 31, 2010 to stop editing when CR 6712 becomes effective.						X				
6712.1.2.1	MACs shall change the status and location of reason code 31715 from T (RTP claims) to a D (deny claims) for claims processed on and after April 1, 2010.	X		X							
6712.1.3	The shared system maintainers shall design the module to accept updates to MUEs using the format in Appendix 1.						X	X	X		
6712.1.4	The shared system maintainers shall expand the size of the maximum units (see Appendix 1) from two (size in the current MUE module) to five.						X	X	X		
6712.2	The shared system maintainer shall allow for the retention of the five most recent unit values for each MUE.						X	X	X		
6712.2.1	The shared system maintainer shall allow for all five values to be active at the same time.						X	X	X		
6712.2.2	The MUE values shall be distinguishable by the begin and end dates for each value. VMS is not checked because the VMS system already meets this requirement.						X	X			
6712.3	The shared system module shall calculate units of service for a service provided over a period of time greater than 1 day as a per day number rounded to the nearest whole number. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.						X				

Number	Requirement	Responsibility(place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIERS	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6712.3.1	For each day in the period, the shared systems shall deny the entire claim line when the units of service for the claim line is greater than the units of service stated in the file. This BR does not apply to the FISS system because the FISS system only allows one date of service per line. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.	X		X	X						
6712.3.1.1	Since contractors that use the FISS have the ability to either return the claim to the provider or deny the claim line, those contractors shall deny the line item.	X		X							
6712.4	The shared system module shall apply MUEs after all other edits and audits have completed and before the claim is sent to CWF. MCS and VMS are not checked because the MCS and VMS systems already meet this requirement.						X				
6712.5	Data centers (Enterprise Data Centers [EDCs] or contractor data centers [CDCs]) shall install the MUE shared system module developed for this CR in time for the implementation date of this CR.	X	X	X	X	X					EDCs and CDCs
6712.6	Contractors shall insure that the MUE shared system module developed in business requirement 6712.1, begins to operate in time so that the entire claims line is denied when the units of service are in excess of the MUE value.	X	X	X	X	X					
6712.7	Medicare contractors shall afford physicians, suppliers, facilities and beneficiaries appeal rights under the Medicare claims appeal process (See Pub 100-4, CPM, chapter 29.)	X	X	X	X	X					
6712.8	Medicare contractors shall refer any request to modify the MUE value for a specific code to: National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907, Carmel, IN 46082-0907	X	X	X	X	X					
6712.8.1	Upon the review of appropriate reconsideration documents provided by a national organization/provider, CMS' data and other CMS resources, the NCCI/MUE Contractor will consult with the CMS MUE Workgroup and a decision shall be made by CMS whether or not to modify the MUE.										NCCI/MUE Contractor and CMS/MUE Workgroup
6712.9	Beginning on the implementation date for this CR, Medicare contractors shall apply MUEs to claims and adjustments with dates of service on or after the beginning effective date of the MUE and on or before the ending effective date of the MUE. VMS is not checked because the VMS system already meets this requirement.	X	X	X	X	X	X	X			

Number	Requirement	Responsibility(place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIERS	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6712.9.1	Shared system maintainers shall continue to insure that MUEs are applied based on date of service. CMS has noted that all shared systems maintainer currently provide this capability.						X	X	X		
6712.10	Contractors shall begin denying the entire claim line when the units of service on that line are in excess of the MUE value and assign MSN message # 15.6, ANSI reason code 151, group code CO (contractual obligation), and remark codes # N362 and MA01 to claims that fail the MUEs.	X	X	X	X	X					
6712.11	Medicare contractors shall classify MUEs as PIMR activity code 21001I in PIMR and activity code 11205 in CAFM.	X	X	X	X	X	X				
6712.12	The filenames to access for the carriers and the FIs are: Test File: MU00.@BF12372.MUE.CARR.TEST02.V* MU00.@BF12372.MUE.FI.TEST02.V* MU00.@BF12372.MUE.DME.TEST02.V* Final File: MU00.@BF12372.MUE.CARR.FINAL01.V* MU00.@BF12372.MUE.FI.FINAL01.V* MU00.@BF12372.MUE.DME.FINAL01.V* Where "*" indicates current generation number for all files **except MU00.@BF12372.MUE.DME. FINAL01. *. For MU00.@BF12372.MUE. DME.FINAL01.V*, "*" indicates version number - MU00.@BF12372.MUE.DME. FINAL01.V* are flat files.**	X	X	X	X	X	X	X	X		BDC, EDC, and CDCs
6712.13	Contractors shall classify MUE denials as coding denials, not as medical necessity denials.	X	X	X	X	X					
6712.13.1	A provider shall not use an Advanced Beneficiary Notice (ABN) to seek payment from a patient for UOS denied due to an MUE.	X	X	X	X	X					Providers
6712.13.2	The MUE denials shall have "provider liability."	X	X	X	X	X					
6712.13.3	The MUE denials cannot be waived nor subject to an ABN.	X	X	X	X	X					
6712.14	Contractors may process claim service lines that exceed MUE limits and also contain a 55 modifier in a manner such that the MUE audit will not systematically deny the service line.	X		X	X	X		X			
6712.14.1	At contractor discretion, contractors may determine that these services must be suspended for contractor review and input.	X		X	X	X		X			

Number	Requirement	Responsibility(place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIERS	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6712.15	Contractors shall refer providers to the Web site: "**http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage**" for current information on the MUE program.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
6712.16	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web sites and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in the contractors next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X	X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	**Recommendations or other supporting information:**
	None

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s):
John Stewart (410) 786-1189, **John.Stewart@CMS.HHS.GOV**,
Val Allen (410) 786-7443 **valeria.allen@cms.hhs.gov**

Post-Implementation contact(s):
John Stewart (410) 786-1189 **John.Stewart@CMS.HHS.GOV**,
Val Allen (410) 786-7443 **valeria.allen@cms.hhs.gov**

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

APPENDIX 1
TABULAR PRESENTATION OF THE FORMAT FOR THE MUE TRANSMISSION

Below are layouts for each of the shared systems. A description of each column on the layouts is provided below. Note that all layouts are the same.

The first column contains HCPCS codes (5 positions). The second column of the first format chart contains the maximum units of service A/B MACs and Medicare fiscal intermediaries shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The second column of the second format chart contains the maximum units of service A/B MACs and Medicare carriers shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The second column of the third format chart contains the maximum units of service DME MACs shall allow per claim line per day for the HCPCS code in column one (5 positions with no decimal places). The third column is the Corresponding Language Example Identification (CLEID) Number (12 positions including a decimal point). The CLEID information is for reference only. The fourth column states the beginning effective date for the edit (7 positions in YYYYDDD format), and the fifth column states the ending effective date of the edit (7 positions in YYYYDDD format). For example, April 1, 2007, is recorded as 2007091 meaning the 91st day of 2007. The fifth column will remain blank until an ending effective date is determined. The last column indicates whether CMS will publish the MUE units on the CMS website: "**http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage**." A "1" indicates that CMS will publish the MUE units on the CMS website.

FORMAT FOR CLAIMS PROCESSED USING THE FISS SYSTEM

HCPCS CODE	MAXIMUM MAC/FI UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES
A = ALPHANUMERIC CHARACTER
X = NUMERIC CHARACTER
YYYYXXX = JULIAN DATE

PUBLICATION INDICATOR
NO = CMS WILL NOT PUBLISH - DO NOT SHARE
YES = CMS WILL PUBLISH - OK TO SHARE

FORMAT FOR CLAIMS PROCESSED USING THE MCS SYSTEM

HCPCS CODE	MAXIMUM MAC/CARRIER UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES
A = ALPHANUMERIC CHARACTER
X = NUMERIC CHARACTER
YYYYXXX = JULIAN DATE

PUBLICATON INDICATOR
NO = CMS WILL NOT PUBLISH - DO NOT SHARE
YES = CMS WILL PUBLISH - OK TO SHARE

FORMAT FOR CLAIMS PROCESSED USING THE VMS SYSTEM

HCPCS CODE	MAXIMUM DME MAC UNITS	CLEID #	BEGINNING EFFECTIVE DATE	ENDING EFFECTIVE DATE	PUBLICATION INDICATOR
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES
AAAAA	XXXXX	AA.AAAAAAAAA	YYYYDDD	YYYYDDD	0=NO 1=YES

DEFINITIONS:

DATES
A = ALPHANUMERIC CHARACTER
X = NUMERIC CHARACTER
YYYYXXX = JULIAN DATE

PUBLICATON INDICATOR
NO = CMS WILL NOT PUBLISH - DO NOT SHARE
YES = CMS WILL PUBLISH - OK TO SHARE

In an effort to increase efficiency and convenience for our users the DME MAC A Supplier Manual is now available as one complete PDF document.

CMS News Flash (GEN)

As a result of the Affordable Care Act (ACA), claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at **http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf** on the Centers for Medicare & Medicaid Services website.

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 website at **http://www.cms.gov/MedicareProviderSupEnroll** and clicking on "Ordering/Referring Report" on the left-hand side.

Attention: All Providers and Suppliers Selected to Participate in the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) Your chance to complete the MCPSS is running out. CMS needs to hear from you. Now is the time to provide CMS with your feedback on your satisfaction with the performance of the Medicare contractor that processes and pays your fee-for-service (FFS) Medicare claims. If you have questions about the survey, need help completing or accessing the online survey tool, or you no longer have your survey access information, please call the MCPSS Provider Helpline at 1-800-835-7012 or send an email to **mcpss@scimetrika.com**. Someone on the MCPSS team will be happy to assist you. Survey responses may also be submitted by telephone, fax, or postal mail. Your feedback is urgently needed now. Don't delay. Please respond today! Don't pass up this golden opportunity to let your voice be heard! For more information about the MCPSS, please visit the CMS MCPSS website at **http://www.cms.gov/mcpss** , or read the CMS MLN Matters Special Edition article, SE1005, at **http://www.cms.gov/MLNMattersArticles/downloads/SE1005.pdf** featuring the survey.

Follow CMS on Twitter to get the latest updates on information you need know about CMS (including Medicare Learning Network updates). Visit **http://www.twitter.com/CMSGov** and stay connected! (Twitter handle = @CMSGov)

The April 2010 Edition of the Medicare Learning Network (MLN) Catalog of Products is now available and may be accessed at **http://www.cms.gov/MLNproducts** on the CMS website. The MLN Products Catalog is an interactive downloadable document that lists all Medicare Learning Network products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All product titles and the word "download" when selected, will link you to the online version of the product. The word "hard copy" when selected, will automatically link you to the MLN Product Ordering page. To access the catalog, click on the link called MLN Product Catalog.

The fifth annual national administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS) is now underway. If you received a letter indicating that you were randomly selected to participate in the 2010 MCPSS, CMS urges you to take a few minutes to go online and complete this important survey via a secure Internet website. Responding online is a convenient, easy, and quick way to provide CMS with your feedback on the performance of the FFS contractor that processes and pays your Medicare claims. Survey questionnaires can also be submitted by mail, secure fax, and over the telephone. To learn more about the MCPSS, please visit the CMS MCPSS website at **http://www.cms.gov/mcpss** or read the CMS Special Edition MLN Matters article, SE1005, located at **http://www.cms.gov/MLNMattersArticles/downloads/SE1005.pdf** on the CMS website.

On March 23, 2010, President Obama signed into law the **Patient Protection and Affordable Care Act (PPACA)**, which creates a 3% add-on to payments made for home health services to patients in rural areas. The add-on applies to episodes ending on or after April 1, 2010, through December 31, 2016. Similar to temporary rural add-on provisions in the past, claims that report a rural state code (code beginning with 999) as the Core Based Statistical Area (CBSA) code for the beneficiary's residence will receive the additional 3% payment. The CBSA code is reported associated with value code 61 on home health claims. The Centers for Medicare & Medicaid Services is working to expeditiously implement the home health rural add-on provision, Section 3131(c), of the PPACA. Be on the alert for more information about this provision and its impact on past and future claims.

On March 23, 2010, President Obama signed into law the **Patient Protection and Affordable Care Act (PPACA)**. The Centers for Medicare & Medicaid Services (CMS) is working hard to expeditiously implement the new law. The law's Medicare fee-for-service provisions have varying effective dates and CMS' first priority is to address provisions with the earliest effective dates. CMS is committed to assuring Medicare providers are well informed as early as possible. For that reason, CMS is urging you to be on the alert for notices and instructions from CMS and from your Medicare fiscal intermediary, carrier, or Medicare Administrative Contractor, on forthcoming policy and operational changes as we implement the PPACA.

The Medicare Fraud and Abuse Web-based Training Course has been revised and is now available - The course provides information helpful for Medicare providers and suppliers involved in providing and billing for services to people with Medicare. This activity provides information that will increase awareness of Medicare fraud and abuse; provide information regarding correct billing practices, and help Medicare providers, suppliers and staff to file claims correctly. The course offers continuing education credits; please see the course description page for details. To access the course, go to the MLN Products page at **http://www.cms.gov/MLNProducts/**, and select the web-based training modules link in the "Related Links Inside CMS" section. Once the web-based training courses page is displayed, select the Medicare Fraud and Abuse WBT from the list provided.

The revised, Guided Pathways to Medicare Resources (1st Quarter 2010), are now available from the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network. Guided Pathways leads Medicare Fee-For-Service providers through a variety of resources organized by topic. Quickly explore these three easy-to-navigate online guides to learn important Medicare policy and requirements. Guided Pathways information is available at **http://www.cms.gov/MLNEdWebGuide/30_Guided_Pathways.asp** on the CMS website.

The revised Medicare Fraud & Abuse fact sheet (February 2010), directs you to a number of sources of information pertaining to Medicare fraud and abuse, and helps you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse. It can be downloaded at **http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf** from the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network.

The revised Understanding the Remittance Advice (RA) for Professional Providers Web-Based Training (WBT), has been made available by the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). Available for Continuing Education credit, this course provides instructions to help fee-for-service Medicare providers and their billing staffs interpret the RA received from Medicare and reconcile it against submitted claims. It additionally provides guidance on how to read Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices (SPRs), as well as information for balancing an RA. This course also presents an overview of software that Medicare provides free to providers in order to view ERAs. This training can be accessed by visiting **http://www.cms.gov/MLNgeninfo/** and scrolling to the "Related Links Inside CMS" page section. Within these links, select Web Based Training (WBT) Modules and then Understanding the Remittance Advice for Professional Providers from the list of training courses provided.

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

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

The official Local Coverage Determination (LCD)
is the version on the Medicare Coverage Database at **http://www.cms.gov/MCD**

Durable Medical Equipment - Documentation of Continued Medical Necessity

Dear Physician,

To assure that correct payment is made for items and services that are provided to Medicare beneficiaries, the need for detailed medical documentation is paramount. If your treatment plan includes durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), Medicare requires that suppliers have access to information from the patient's medical record that addresses the coverage criteria for the items prescribed. Accessibility of pertinent medical record information protects both the patient and the supplier in the event of an audit.

For many items, Medicare coverage requires that continued use must be assessed and documented by the treating physician. Rental items such as oxygen, nebulizers, CPAP, wheelchairs, and hospital beds and recurring supplies such as glucose test strips, urological supplies, and ostomy supplies must be periodically justified in the medical record. Ongoing need for and use of the item must be documented in your patient's record in order for Medicare to continue reimbursement for the equipment or supplies. In these instances, you or your staff should regularly review the use of medical equipment and supplies by your patients. This review should be no different than your review of the continued need for medication or other treatments.

Recent audits conducted by the Comprehensive Error Rate Testing program have shown that patients' medical records frequently lack sufficient information to justify the continued need for the item(s) ordered. This results in claim denials for the DMEPOS supplier and potential financial liability for your patient. When a claim is denied, the DMEPOS supplier may be unable to continue to provide the item(s) ordered. Clearly, this outcome may affect your care plan. As the patient's treating physician, it is important that you understand the applicable Medicare coverage criteria related to the DMEPOS you are prescribing and adequately document the applicable policy criteria for those items on an ongoing basis.

Medicare DMEPOS Local Coverage Determinations (LCDs), which include details on specific coverage criteria, are available in the Medicare Coverage Database or on each DME MAC's Web site.

Sincerely,

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

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

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

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

Detailed Written Orders (GEN)

Medicare requires an order for every item (except repairs) of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Detailed written orders are used to confirm what was ordered by the treating physician following the supplier's receipt of a verbal or written dispensing order. Detailed written orders must include separately billable options, accessories or supplies related to the base item that is ordered. Detailed written orders must not be used to add unrelated items, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

> Example: The treating physician calls the supplier and prescribes a glucose monitor with a verbal order. The supplier can then create a detailed written order that includes an itemized listing of all directly related, separately billable items - i.e., the glucose monitor, test strips, lancets, calibration solution, batteries and lancing device. This detailed written order is then returned to the physician for their signature.

Although the initial dispensing order from the physician did not specifically include the test strips, lancets, and other supplies, they are clearly related to the glucose monitor. Therefore, it is an acceptable detailed written order. For detailed written orders of this type, no further action is required from the physician beyond their signature and date. However, for other type of detailed written orders other actions by the physician may be required. (See below)

In the example above, it is not acceptable for the supplier to include additional, unprescribed and unrelated items, such as a vacuum erection device, water circulating heating pad or wrist orthosis to the detailed written order. While the test strips, lancets, and other supplies are related to the glucose monitor in the original order, the vacuum erection device, water circulating heating pad and wrist orthosis are not related and therefore must not be included on the detailed written order.

Some suppliers use preprinted forms for their detailed written orders that include a listing of many different items, not all of which may be needed by an individual beneficiary. These listings often create incompatible combinations. For example, an order form for CPAP accessories might list all possible interfaces. On these forms, the final document that is signed and dated by the physician must clearly identify the specific items that are being ordered for that patient. This may be accomplished in one of two ways:

- The supplier may indicate the items that are being provided before sending the form to the physician. The physician can then review the form and accept either the items marked by the supplier or, make any necessary changes. The physician must then initial and date the revised entries; or,

- The supplier may send the form to the physician without any items selected and ask the physician to indicate which items are being ordered. The physician must make their choice clear. Check marks, circling items or other affirmative indicators are acceptable ways to show that the physician selected the item(s).

In each case, the physician must sign and date the form.

The following are examples (not all-inclusive) of forms listing multiple items, which would be considered invalid detailed written orders:

- Forms listing incompatible items without specific items being selected. For example, for CPAP, a form which includes full-face mask, nasal mask, and nasal pillows with none being specifically selected by the physician.

- Forms in which incompatible items are checked off or selected, by either the supplier or the physician. For example, a form which includes full-face mask, nasal mask, and nasal pillows and two or all three are selected.

Refer to the *Supplier Manual* and the LCDs for additional information about order requirements.

Hand-Finger Orthoses (L3923) - Use of CG Modifier (O&P)

Elastic garments do not meet the statutory definition of a brace. Code L3923 (Hand finger orthosis, without joints, prefabricated) includes both elastic and non-elastic items.

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

If a hand-finger garment is made primarily of elastic material, it must be billed with code A4466 (Garment, belt, sleeve or other covering elastic or similar stretchable material, any type, each) and not code L3923. Claims billed with code A4466 be denied as noncovered, no benefit category. Effective for claims with dates of service on or after July 1, 2010, if an L3923 orthosis has a rigid plastic or metal component, the supplier must add the CG modifier (policy criteria applied) to the code. Claims for L3923 billed without a CG modifier will be rejected as incorrect coding.

All products that are currently listed as code L3923 in the DMECS Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor web site will be end-dated June 30, 2010. Manufacturers must resubmit a new Coding Verification Review request to the PDAC if they want their product to be listed in DMECS for dates of service on or after July 1, 2010.

Suppliers should contact the PDAC with questions concerning the correct coding of these items.

External Infusion Pump LCD - Immune Globulin Subcutaneous (Human), 20% Liquid (Hizentra™) (DRU)

A new subcutaneous immune globulin (SCIG) preparation, **Immune Globulin Subcutaneous (Human), 20% Liquid (Hizentra™)**, has been approved for use by the Food and Drug Administration. This preparation meets the requirements necessary for inclusion in the DME MAC External Infusion Pump LCD as a covered SCIG when used for the treatment of primary immune deficiency disease. Coverage is effective for claims with dates of service on or after March 4, 2010.

Claims for Hizentra™ administered with a DME infusion pump should be submitted using HCPCS code

J7799 - NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME

Hizentra™ is supplied in 5ml (1g protein), 10 ml (2g protein), and 20 ml (4g protein) vials. One unit of service equals 5 ml (1g protein). Since the amount of SCIG for each patient is individualized, each dose must be prepared using the combination of vial sizes that result in the least amount of wastage for the dosage amount being administered.

An E0779 infusion pump is covered for the administration of subcutaneous immune globulin.

Refer to the External Infusion Pump LCD for additional information about the coverage of SCIG. Hizentra™ will be added to a future revision of the LCD.

Glucose Monitors and Supplies

Dear Physician,

Glucose monitor supplies have consistently been one of the highest sources of errors in medical reviews performed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Comprehensive Error Rate Testing (CERT) contractor. It is your responsibility as the ordering physician to determine and document the medical necessity for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items. The following information is intended to provide you with guidance on Medicare's coverage and documentation requirements for glucose monitors and testing supplies.

COVERAGE
Glucose monitors and related supplies are covered for patients with diabetes (ICD-9 Codes 249.00 - 250.93) if they or their caregiver can be trained to use the prescribed device appropriately.

The Glucose Monitors Local Coverage Determinations (LCDs) of the DME MACs define the quantity of test strips and lancets that are covered, if the basic criterion above is met.

Treatment regimen	Basic coverage Test strips and lancets	Average testing
Insulin treated	100 per month	3x per day
Non-insulin treated	100 per 3 months	1x per day

Additional quantities of test strips can be considered for coverage **if they are deemed medically necessary** - see following section. Coverage is also provided for a lancing device, calibration solution, and replacement batteries.

MEDICAL NECESSITY DOCUMENTATION
CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. (Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC).

There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and,
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
  - Justification for testing frequency; and,
  - Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
  - Names, dosages, and timing of administration of medications used to treat the diabetes;
  - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
  - Review of beneficiary-maintained log of glucose testing values;
  - Changes in the patient's treatment regimen as a result of glucose testing results review;
  - Dosage adjustments that the patient should make on their own based on self-testing results;
  - Laboratory tests indicating level of glycemic control (e.g., hemoglobin A1C);
  - Other therapeutic interventions and results.

  Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

- Documentation by the beneficiary of the actual frequency of testing.
  - Logs of self-testing values including the date, time, and results
  - Information about medication dosage adjustments related to the results is also helpful.

ORDERS

There must be a written order for all testing supplies. The written order must contain the following elements:

1. Item(s) to be dispensed;
2. Frequency of testing ("as needed" is not acceptable);
3. Physician's signature;
4. Signature date;
5. Start date of order - only required if start date is different than signature date.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing, a change in supplier, or a new treating physician.

Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

This article is only intended to be a general summary. It is not intended to take the place of the written law, regulations, national or local coverage determinations. The LCD for Glucose Monitors can be found in the Medicare Coverage Database on the CMS web site at **http://www.cms.gov/mcd/search.asp?from2=search.asp&** (search "Glucose Monitors").

Sincerely,

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Group 3 Support Surfaces - Coverage Criteria Reminder (MOB)

Recently it has come to the attention of the DME MACs that there is confusion regarding the coverage of air-fluidized bed technology (Group 3 support surfaces) for patients who have undergone surgical flap or graft procedures. Medicare does not cover air-fluidized beds in the home setting for patients with surgical grafts or flaps. Coverage for patients with these conditions is outlined in the LCD for Group 2 support surfaces. Coverage of a Group 3 support surface is limited to bed-ridden or chair-bound patients with stage III or stage IV pressure ulcers that without the use of an air-fluidized bed would be institutionalized. The LCD contains additional coverage criteria including physician oversight requirements, conservative management and other provisions related to Medicare reimbursement for these products. Suppliers and physicians are encouraged to consult the LCD for full coverage, coding and documentation requirements.

HCPCS Code Update - 2010 (GEN)

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2010.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2010.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued/deleted will continue to be valid for claims with dates of service on or before December 31, 2009, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2010.

There is no grace period that would allow submission of the discontinued code for dates of service in 2010.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2010.

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

Ankle-Foot and Knee-Ankle-Foot Orthoses

	Added Code
Code	**Narrative**
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered*)

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L4396	STATIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, PRESSURE REDUCTION, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	STATIC OR DYNAMIC ANKLE FOOT ORTHOSIS, INCLUDING SOFT INTERFACE MATERIAL, ADJUSTABLE FOR FIT, FOR POSITIONING, MAY BE USED FOR MINIMAL AMBULATION, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

External Breast Prostheses

	Added Code
Code	**Narrative**
L8031	BREAST PROSTHESIS, SILICONE OR EQUAL, WITH INTEGRAL ADHESIVE
L8032	NIPPLE PROSTHESIS, REUSABLE, ANY TYPE, EACH

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L8030	BREAST PROSTHESIS, SILICONE OR EQUAL	BREAST PROSTHESIS, SILICONE OR EQUAL, WITHOUT INTEGRAL ADHESIVE

Facial Prostheses

	Added Code
Code	**Narrative**
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50	A4456

Knee Orthoses

	Added Code
Code	**Narrative**
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered*)

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
L1800	KNEE ORTHOSIS, ELASTIC WITH STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L1815	KNEE ORTHOSIS, ELASTIC OR OTHER ELASTIC TYPE MATERIAL WITH CONDYLAR PAD(S), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L1825	KNEE ORTHOSIS, ELASTIC KNEE CAP, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L1901	ANKLE ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L2770	ADDITION TO LOWER EXTREMITY ORTHOSIS, ANY MATERIAL - PER BAR OR JOINT	None

Lower Limb Prostheses

	Added Code
Code	**Narrative**
L5973	ENDOSKELETAL ANKLE FOOT SYSTEM, MICROPROCESSOR CONTROLLED FEATURE, DORSIFLEXION AND/OR PLANTAR FLEXION CONTROL, INCLUDES POWER SOURCE

Miscellaneous

	Added Code
Code	**Narrative**
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered*)

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E0700	SAFETY EQUIPMENT (E.G., BELT, HARNESS OR VEST)	SAFETY EQUIPMENT, DEVICE OR ACCESSORY, ANY TYPE
E0249	PAD FOR WATER CIRCULATING HEAT UNIT	PAD FOR WATER CIRCULATING HEAT UNIT, FOR REPLACEMENT ONLY

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
E1340	REPAIR OR NONROUTINE SERVICE FOR DURABLE MEDICAL EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES (*Note: Invalid for claim submission to Medicare for dates of service on or after 04/01/2009*)	K0739 or K0740 (Note: Effective 04/01/2009)
L0210	THORACIC, RIB BELT	A4466
L3651	SHOULDER ORTHOSIS, SINGLE SHOULDER, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3652	SHOULDER ORTHOSIS, DOUBLE SHOULDER, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3700	ELBOW ORTHOSIS, ELASTIC WITH STAYS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT	A4466
L3701	ELBOW ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3909	WRIST ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L3911	WRIST HAND FINGER ORTHOSIS, ELASTIC, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (E.G. NEOPRENE, LYCRA)	A4466
L6639	UPPER EXTREMITY ADDITION, HEAVY DUTY FEATURE, ANY ELBOW	None

Nebulizers

	Added Code
Code	**Narrative**
Q4074	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 20 MICROGRAMS

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
Q4080	ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS	Q4074

Ostomy Supplies

	Added Code
Code	**Narrative**
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50	A4456

Oxygen and Oxygen Equipment

	Added Code
Code	**Narrative**
E0433	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUEFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING, WITH OR WITHOUT SUPPLY RESERVOIR AND CONTENTS GAUGE

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E0441	OXYGEN CONTENTS, GASEOUS (FOR USE WITH OWNED GASEOUS STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1UNIT	STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
E0442	OXYGEN CONTENTS, LIQUID (FOR USE WITH OWNED LIQUID STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED), 1 MONTH'S SUPPLY = 1 UNIT	STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT
E0443	PORTABLE OXYGEN CONTENTS, GASEOUS (FOR USE ONLY WITH PORTABLE GASEOUS SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT	PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
E0444	PORTABLE OXYGEN CONTENTS, LIQUID (FOR USE ONLY WITH PORTABLE LIQUID SYSTEMS WHEN NO STATIONARY GAS OR LIQUID SYSTEM IS USED), 1 MONTH'S SUPPLY = 1 UNIT	PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT

Patient Lifts

	Added Code
Code	**Narrative**
E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS

Spinal Orthoses

	Added Code
Code	**Narrative**
A4466	GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH (*Note: Noncovered*)

Surgical Dressings

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A6549	GRADIENT COMPRESSION STOCKING, NOT OTHERWISE SPECIFIED (*Note: Noncovered*)	GRADIENT COMPRESSION STOCKING/SLEEVE, NOT OTHERWISE SPECIFIED

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING (*Note: Invalid for claim submission to Medicare for dates of service on or after 01/01/2007*)	A6251 (Note: Effective 01/01/2007)
A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING (*Note: Invalid for claim submission to Medicare for dates of service on or after 01/01/2007*)	A6252 (Note: Effective 01/01/2007)
A6202	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING (*Note: Invalid for claim submission to Medicare for dates of service on or after 01/01/2007*)	A6253 (Note: Effective 01/01/2007)
A6542	GRADIENT COMPRESSION STOCKING, CUSTOM MADE	A6549
A6543	GRADIENT COMPRESSION STOCKING, LYMPHEDEMA	A6549

Urological Supplies

	Added Code
Code	**Narrative**
A4336	INCONTINENCE SUPPLY, URETHRAL INSERT, ANY TYPE, EACH
A4360	DISPOSABLE EXTERNAL URETHRAL CLAMP OR COMPRESSION DEVICE, WITH PAD AND/OR POUCH, EACH (*Note: Noncovered*)
A4456	ADHESIVE REMOVER, WIPES, ANY TYPE, EACH

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
A4365	ADHESIVE REMOVER WIPES, ANY TYPE, PER 50	A4456

Wheelchair Options and Accessories

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
E2223	MANUAL WHEELCHAIR ACCESSORY, VALVE, ANY TYPE, REPLACEMENT ONLY, EACH	None
E2393	POWER WHEELCHAIR ACCESSORY, VALVE FOR PNEUMATIC TIRE TUBE, ANY TYPE, REPLACEMENT ONLY, EACH	None
E2399	POWER WHEELCHAIR ACCESSORY, NOT OTHERWISE CLASSIFIED INTERFACE, INCLUDING ALL RELATED ELECTRONICS AND ANY TYPE MOUNTING HARDWARE	K0108

Modifiers

	Added Modifiers
Modifier	**Narrative**
J4	DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED BY A HOSPITAL UPON DISCHARGE

LCD and Policy Article Revision - Summary for April 1, 2010 (GEN)

Outlined below are the principal changes to a DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that has been revised and posted. Please review the entire LCD and related Policy Article for complete information.

Oral Anticancer Drugs

LCD

Revision Effective Date: 01/01/2010

CMS National Coverage Policy

Added: References to IOM & SSA

HCPCS CODES AND MODIFIERS:

Added: Fludarabine phosphate

Policy Article

Revision Effective Date: 06/01/2010

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Clarified: Criterion 3 to indicate coverage for those ICD-9 diagnoses specifically indicated under IOM 100-02, Section 50 - Drugs and Biologicals and under the Social Security Act, Sec.1861(s) (Q).

Added: Coverage possible at appeal for claims not listed in the section "ICD-9 Codes that are Covered" which can be shown consistent with IOM 100-02, Section 50 - Drugs and Biologicals and with the Social Security Act, Sec.1861(s) (Q).

ICD-9 CODES THAT ARE COVERED:

Changed: All ICD-9 diagnoses to those specifically indicated under IOM 100-02, Section 50 - Drugs and Biologicals and under the Social Security Act, Sec.1861(s)(Q).

Added: Diagnoses for fludarabine phosphate (effective 1/01/2010).

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

LCD and Policy Article Revisions Summary for March 11, 2010 (GEN)

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

External Breast Prostheses

LCD

Revision Effective Date: 01/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:

Added: Coverage information specific to mastectomy bras (L8000).

Added: Coverage information specific to breast prostheses, silicone or equal, with integral adhesive (L8031).

Added: Coverage information on quantity dispensed at a time.

HCPCS CODES AND MODIFIERS:

Added: L8031, L8032

Revised: L8030

Policy Article

Revision Effective Date: 01/01/2010

NON-MEDICAL NECESSITY AND COVERAGE AND PAYMENT RULES:

Added: Nipple prostheses have a 3 month reasonable lifetime expectancy.

CODING GUIDELINES:

Added: Description for L8000.

Revised: RT/LT modifier instructions.

Changed: SADMERC to PDAC.

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

LCD

Revision Effective Date: 04/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Program Integrity Manual instructions on refills of accessories.

Added: Replacement instructions for beneficiaries already in Medicare.

Revised: Types of sleep tests.

Revised: Coverage of replacement devices and/or accessories.

Revised: Beneficiaries entering Medicare instructions.

DOCUMENTATION REQUIREMENTS:

Added: Replacement instructions for beneficiaries already in Medicare.

Revised: Documentation of replacement devices and/or accessories.

Revised: Beneficiaries entering Medicare instructions.

Policy Article
Revision Effective Date: 04/01/2010
CODING GUIDELINES:
Revised: Use of RAD term.
Revised: Definition of E0470 and E0471.

Spinal Orthoses: TLSO and LSO
Policy Article
Revision Effective Date: 07/01/2010
CODING GUIDELINES:
Revised: Requirement for coding verification review by the PDAC.

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

LCD Revision - Summary for April 29, 2010 (GEN)

Outlined below are the principal changes to a DME MAC Local Coverage Determination (LCD) that has been revised and posted. Please review the entire LCD for complete information.

External Infusion Pumps
LCD
Revision Effective Date: 04/19/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed specific coverage and the least costly alternative provisions from liposomal amphotericin B (J0287-J0289)
DOCUMENTATION REQUIREMENTS:
Removed KX requirements for J0287-J0289

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

Mounting Hardware - E1028 - Billing Reminder (MOB)

Recently it has come to the attention of the DME MACs that there is confusion regarding the billing of mounting hardware for wheelchair accessories. This article provides instructions on appropriate billing of mounting hardware Healthcare Common Procedure Coding System (HCPCS) code E1028.

Code E1028 is described as a wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory. The local coverage determination (LCD) for Wheelchair Options and Accessories states: "One example (not all-inclusive) of a covered indication for swingaway, retractable, or removable hardware (E1028) would be to move the component out of the way so that a patient can perform a slide transfer to a chair or bed."

Since this code encompasses various types of hardware, suppliers must add a description for each E1028 billed. For example, if billing an E1028 for a joystick, add the comment "retractable joystick mounting". In addition, the description provided should coincide with a corresponding HCPCS code that requires or can accommodate specialty hardware. For example, if billing an E1028 for swingaway lateral support hardware, the corresponding code for lateral supports should be on the same claim. If the billing order does not allow this, then the corresponding code must be in the billing history for the E1028 to be paid.

Suppliers are reminded that mounting hardware, fixed, is not separately payable.

Suppliers are encouraged to read the entire LCD and policy article for Wheelchair Options and Accessories and Wheelchair Seating for additional coverage, coding and documentation requirements.

Billing Information - Oral Appliances for Obstructive Sleep Apnea (OAOSA) (SPE)

Many providers of OAOSA items are not traditional DME suppliers, coming instead from the medical and dental communities. Reimbursement policy for DME often differs from the billing for E&M services or medical and surgical procedures. This article will review some key elements about billing for OAOSA. Please note that this is not intended as an exhaustive discussion of all DME billing requirements.

Medicare provides reimbursement for OAOSA (E0485, E0486) under the Durable Medical Equipment (DME) Benefit. This means that, in order to bill for these items, a provider must enroll as a Medicare DME Supplier. Claims for these items must be submitted to the DME Medicare Administrative Contractor (MAC). Do not submit claims to a Part B carrier or to an A/B MAC. Information about enrolling as a DME Supplier is available from the National Supplier Clearinghouse at, **http://www.palmettogba.com/nsc** or by calling, (866) 238-9652.

Billing for OAOSA items is all-inclusive, once the decision has been made to provide the device. Reimbursement for these items includes all time, labor, materials, professional services, and radiology and lab costs, necessary to provide and fit the device. It also includes all costs associated with follow-up, fitting, and any adjustments after the item are provided.

Some evaluation and management (E&M) services may be separately billable. Contact your Medicare Part B carrier or A/B MAC for information.

For OAOSA (E0485, E0486), the unit of service is for the entire, complete item. Some items have multiple components. Each component is not separately billable. For example, billing E0486 (2 units) for a 2-piece appliance, top & bottom and E0486 (1 unit) for the piece that holds the tongue back, for a total of 3 units of service is not correct. One unit of service should be billed for the entire device, inclusive of all components.

Selection of the correct HCPCS code is important. The essential difference between the codes is that E0485 is for a prefabricated item while E0486 is custom fabricated. The code narrative for E0485 is:

> E0485 ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

A prefabricated device is defined as one that may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient i.e., custom fitted. An OAOSA that is assembled from prefabricated components is considered prefabricated. Any device that does not meet the definition of a custom-fabricated item is considered prefabricated.

The code narrative for E0486 is:

> E0486 ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT

A custom-fabricated OAOSA is defined as one that is individually made for a specific patient (no other patient would be able to use this item) starting with basic materials. It involves substantial work to produce, usually by a specialized lab. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item.

For additional information on Medicare billing requirements for DME items refer to the *Supplier Manual* which can be found on each DME MAC Web site.

Power Wheelchair Electronics Clarification (MOB)

Recently it has come to the attention of the DME MACs that there is confusion regarding the billing of wheelchair electronics. This article provides instructions on appropriate billing of power wheelchair electronics, such as motors, controllers, harnesses and interfaces.

When one power seating function/actuator/motor is provided on a power wheelchair, only one unit of E2310 (electronic connection between wheelchair controller and one power seating system motor) is allowed. An expandable controller (E2377) is not allowed in this situation unless a specialty interface is used.

> **Example:** E1002 (power seating system, tilt only) is added to a power wheelchair. A power tilt system uses one power seating motor/actuator.

If two power seating functions/actuators/motors are provided, then one unit of E2311 (electronic connection between wheelchair controller and two or more power seating system motors) is allowed. An expandable controller (E2377) is not allowed in this situation unless a specialty interface is used.

> **Example:** E1002 and power elevating leg rests, E1010 (which include articulating or non-articulating), are added to a power wheelchair. Each has one actuator or power seating system motor, for a total of two.

E2377 (expandable controller), E2313 (harness for upgrade to expandable controller and E2311 (electronic connection between wheelchair controller and two or more power seating system motors) are allowed when three or more power seating system motors are involved.

> **Example:** Power tilt, recline and power elevating leg rests/foot platform involve three power seating system motors.

An expandable controller (E2377) and the wiring harness (E2313) are also billed when a specialty interface is required, i.e., head control interface (E2327, E2328, E2329, E2330), sip-n-puff interface (E2325), joystick other than a standard proportional joystick (E2312, E2321, E2373), or multi-switch hand control interface (E2322).

There is no separate billing/payment for electronics if a non-expandable controller and a standard proportional joystick (integrated or remote) are provided.

Codes E2310 and E2311 describe electronic components that allow the patient to control two or more of the following motors from a single interface, e.g., proportional joystick, touchpad, or nonproportional interface:

- Power tilt
- Power recline, with or without shear reduction
- Combination power tilt and recline, with or without shear reduction
- Power leg elevation with or without articulation, power center mount elevating foot platform with or without articulating properties.

The interface includes a function selection switch that allows the patient to select the motor that is being controlled and an indicator feature to visually show which function has been selected. When the wheelchair drive function has been selected, the indicator feature may also show the direction that has been selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface. Payment for the interface code includes an allowance for fixed mounting hardware for the control box and the display box, if present.

A harness (E2313) describes all the wires, fuse boxes, fuses, circuits, switches, etc. that are required for the operation of an expandable controller (E2377). It also includes all the necessary fasteners, connectors, and mounting hardware.

There is no separate billing for control buttons, displays, switches, etc. There is no separate billing for fixed mounting hardware, regardless of the body part used to activate the joystick.

Suppliers are encouraged to read the entire DME MAC local coverage determination and policy article for Wheelchair Options and Accessories for additional coverage, coding and documentation requirements.

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 widespread pre-payment probe review findings. The previous quarterly findings covered the period from October 1, 2009 through December 31, 2009 and resulted in a 72.1% Charge Denial Rate (CDR).

DME MAC A recently concluded a quarterly pre-payment review. The results of the quarterly review for claims paid from January 1, 2010 through March 31, 2010, identified the following:

- This review involved prepayment complex medical review of 119 claims submitted by 81 suppliers, of which, 67 claims were allowed and 52 were denied resulting in a claim denial percentage of 43.7%. 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 45.7%.

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

- Incomplete documentation (67.3%) (examples):
  - Incomplete 7 elements / prescription, (missing 1 or more of the 7 elements)
  - No Face to Face examination
  - No mobility evaluation
  - No home evaluation / assessment
  - PT / OT evaluation but no attestation of financial relationship
  - Detail product description signature and/or date illegible
  - No HCPCS codes and/or no allowances included on detail product description
- Determined to be medically unnecessary (30.8%) (examples):
  - Face to Face; not a physical exam; did not address mobility issue
  - Upper extremity / lower extremity issues not addressed
  - ROM and strength indicated did not justify PWD
  - Face to Face did not support medical necessity
  - Insufficient physical examination, utilized checklist format

To justify the discontinuation of a pre-payment audit, the charge denial rate must reflect a reduction of 70% or more from the previous quarterly findings. 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**, November 05, 2009 educational article **Power Mobility Devices - 7-Element Order**, and the **Power Mobility Devices (L21271) LCD**.

Spinal Orthoses - Coding Verification Review Requirement (O&P)

The **Spinal Orthoses: TLSO and LSO - Policy Article - Effective July 2010** published March 11, 2010 contains revised coding guidelines requiring certain products to be evaluated by the Pricing, Data Analysis, and Coding (PDAC) contractor for proper coding. Coding verification will be required for both prefabricated and custom fabricated products. Products evaluated by the PDAC will be listed on the PDAC Durable Medical Equipment Coding System (DMECS) web site at **http://www.dmepdac.com/dmecsapp/do/search**. Products that do not appear in the DMECS Product Classification List must be coded A9270. These revised requirements are effective for claims with dates of service on or after July 1, 2010.

The Coding Guidelines section of the Policy Article states:

> Effective for claims with dates of service on or after July 1, 2010, the only products that may be billed using codes L0450, L0454-L0472, L0488-L0492, L0625-L0628, L0630, L0631, L0633, L0635, L0637, and L0639 for prefabricated orthoses are those that are specified in the Product Classification List on the Pricing, Data Analysis, and Coding (PDAC) contractor Web site.
>
> There are two categories custom fabricated spinal orthoses (codes L0452, L0480-L0486, L0629, L0632, L0634, L0636, L0638, and L0640):
>
> - Orthoses that are custom fabricated by a manufacturer / central fabrication facility and then sent to someone other than the patient. Effective for claims with dates of service on or after July 1, 2010, these items may be billed using one of these codes only if they are listed in the Product Classification List on the PDAC Web site.
> - Orthoses that are custom fabricated from raw materials and are dispensed directly to the patient by the entity that fabricated the orthosis. These items do not have to be listed on the PDAC Web site in order to be billed using a custom fabricated spinal orthosis code. However, the supplier must provide a list of the materials that were used and a description of the custom fabrication process on request.
>
> Effective for claims with dates of service on or after July 1, 2010, prefabricated spinal orthoses and spinal orthoses that are custom fabricated by a manufacturer / central fabrication facility which have not received coding verification review from the PDAC must be billed with code A9270.

Refer to the complete Local Coverage Determination and Policy Article for additional information.

Therapeutic Shoes - In-Person Fitting and Delivery (O&P)

Appendix C of the DMEPOS Quality Standards published in October 2008 addresses specific requirements for orthoses, prostheses, prosthetic devices, and therapeutic shoes. Those standards include requirements for "an in-person diagnosis-specific functional clinical examination" by the supplier to determine the need for a particular item as well as "face-to-face fitting/delivery" by the supplier. Therefore, in order for therapeutic shoes, inserts, and shoe modifications to be covered, both of the following criteria must be met:

1. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient; and,

2. At the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient to ensure that the shoes/inserts/modifications are properly fit and meet the beneficiary's needs.

In order to meet these criteria, effective for claims with dates of service on or after July 1, 2010, the following documentation requirements must be met:

- The in-person evaluation prior to selecting the items must include at least an examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications. For all shoes, it must include taking measurements of the patient's feet. For custom molded shoes (A5501) and inserts (A5513), this visit must also include taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.

- The in-person visit at the time of delivery must include an assessment of the fit of the shoes and inserts with the patient wearing them.

Depending on the items ordered, both the evaluation and delivery could occur on the same day if the supplier had both a sufficient array of sizes and types of shoes/inserts and adequate equipment on site to provide the items that meet the beneficiary's needs. Both components of the visit (criteria 1 and 2, above) must be clearly documented.

Documentation of these visits must be available to the DME MAC, PSC/ZPIC, RAC, or CERT contractor on request. If one or more of these requirements are not met, the claim will be denied as statutorily noncovered.

This information will be incorporated in a future revision of the Therapeutic Shoes policy. Refer to the Therapeutic Shoes Local Coverage Determination and Policy Article for additional information regarding coverage, coding, and documentation.

Widespread Prepayment Probe for Nebulizers (L11499) - Nebulizers with Compressor (E0570) (SPE)

DME MAC A will be initiating a widespread prepayment probe review of claims for Nebulizers with Compressor (E0570). This review is being initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

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

Documentation should include the following per LCD (L11499) - Nebulizers:

A. A detailed order* that includes the following:
   1. Patient Name
   2. The Description of item to be dispensed
   3. The type of solution
   4. Administration instructions:
      a. Amount of Solution
      b. Frequency of use
   5. The ordering physician's legible signature
   6. 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).*

B. Clinical records that document the treating physician's oversight, continued medical necessity, and the patient's compliance to the treating physician's treatment plan for the aerosol treatments.

C. A payable diagnosis

D. Delivery slip

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 Nebulizers LCD on the DME MAC A Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

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

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

Billing Reminder: Narrative Requirements for Supplies and Accessories Used with Beneficiary Owned Equipment (GEN)

Suppliers are reminded that additional documentation is required in situations where supplies and accessories are provided for a piece of equipment not paid for by Fee-For-Service (FFS) Medicare. In addition, drugs used with a nebulizer or external infusion pump would be considered supplies to a covered piece of DME and must meet the same documentation requirements outlined below.

For supplies and accessories used with equipment purchased privately or by another insurer, all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

- HCPCS code of base equipment; and
- A notation that this equipment is beneficiary-owned; and
- Date the patient obtained the equipment (Month and Year at a minimum)

Example narrative for nebulizer drugs and supplies used with a beneficiary owned nebulizer:
BENEFICIARY OWNED E0570 PURCHASED MAY 2007

Example narrative for CPAP supplies for a beneficiary owned CPAP:
BENEFICIARY OWNED E0601 PURCHASED JUNE 2005

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

Claims denied for missing information on the base piece of equipment may be submitted to written reopenings with the required documentation. If a claim for the base piece of equipment was subsequently submitted after the claim for the supplies and/or accessories denied; the claim can be corrected via the telephone reopenings process.

Suppliers can verify payment or record of the base piece of equipment by accessing the CMN Status Option 3 in the Interactive Voice Response (IVR) System. An **IVR User Guide** is available to assist in this process.

Additional information is available in the April 2009 Medical Review Bulletin titled, "**Supplies and Accessories Used With Beneficiary Owned Equipment April 2009 Clarification**."

Billing Reminders for Vision Claims (VIS)

The following are some important billing reminders when submitting vision claims.

Deluxe frames and progressive lenses are billed using two claim lines.

Deluxe Frames
Deluxe frames are billed using code V2020, on the first line, for the cost of the standard frame, and V2025, on the second line, for the difference between the charges for the deluxe frame and the standard frame.

Example: When the beneficiary chooses a pair of deluxe frames with a cost of $125.00, the claim should be submitted using V2020 (standard frame), on the first line, for the cost of the standard frame, and V2025 (deluxe frame), on the second line, for the difference between the standard frame and the deluxe frame.

$125.00 - $56.55 = $68.45

CMS 1500 or Electronic Equivalent

Item: 24A	24B	24D	24F	24G
Date of service	Place of service	HCPCS & Modifiers	Charges	Days or Units
3/1/2010	12	V2020	$56.55	1
3/1/2010	12	V2025	$68.45	1

Progressive Lenses
Progressive lenses are billed using two lines. The first line would have the appropriate code for the standard bifocal (V2200 through V2299), or trifocal (V2300 through V2399), and the second line would have code V2781 for the difference between the progressive lens and the standard bifocal/trifocal.

Example: When the beneficiary chooses a progressive lens with a cost of $100.00 per lens ($200.00 for the pair of lenses), the claim should be submitted using code V2200 (sphere, bifocal, plano to plus or minus bifocal) and code V2781 (progressive lens, per lens).

$200.00 - $119.58 = $80.42

Item: 24A	24B	24D	24F	24G
Date of service	Place of service	HCPCS & Modifiers	Charges	Days or Units
3/1/2010	12	V2200RTLT	$119.58	2
3/1/2010	12	V2781RTLT	$80.42	2

Please note: Items that can be billed bilaterally are required to have a RT (right side) and/or LT (left side) modifier appended to the Healthcare Common Procedure Coding System (HCPCS) code.

Add-on Features
Please note: Medicare reimburses the following items if they are specifically ordered by the treating physician and are not patient preference only. The KX modifier must be appended to the HCPCS code only if the specific documentation required by the Local Coverage Determination (LCD) is in the supplier's file. If these items are billed without a KX, GA, or GZ modifier they will be rejected as missing information - refer to the GA, GZ, KX section of the article for more information.

V2744 - V2745 - Tints
V2750 - Anti-reflective coating
V2780 - Oversized Lenses:

Example: If you are billing the right eye for a bifocal (code V2200) and the left eye for a trifocal (code V2309), the correct procedure codes and modifiers would be: V2200RT; V2309LT.

The physician has also ordered anti-reflective coating(V2750) for both lenses.

The complete claim form for a deluxe pair of frames with a bifocal and trifocal lens and anti-reflective coating (prescribed by the ordering physician) would be submitted as follows.

Item: 24A	24B	24D	24F	24G
Date of service	Place of service	HCPCS & Modifiers	Charges	Days or Units
3/1/2010	12	V2020	$56.55	1
3/1/2010	12	V2025	$68.45	1
3/1/2010	12	V2200RT	$59.79	1
3/1/2010	12	V2309LT	$94.33	1
3/1/2010	12	V2750KXRTLT	$29.60	2

Noncovered Items
The following items will be denied as noncovered by the Medicare program:

V2760 - Scratch resistant coating
V2761 - Mirror coating
V2762 - Polarization
V2781 - Progressive lenses

V2702 - Deluxe lens feature
V2756 - Eyeglass cases
V2786 - Specialty occupational multi-focal lenses
V2799 - Normal Saline, Contact lens cleaning solution
V2600 - V2615 - Low vision aids

Modifiers
The Refractive Lenses medical policy utilizes the following modifiers:

EY - No physician or other health care provider order for this item or service
GA - Waiver of liability on file
GZ - Item or service expected to be denied as not reasonable and necessary
KX - Requirements specified in the medical policy have been met
LT - Left side
RT - Right side

EY
An order for the lens(es) and related features must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code. If the supplier has obtained a physician's order for some, but not all, of the items provided to a particular beneficiary, the supplier must submit a separate claim for the items dispensed without a physician's order. Claims submitted incorrectly with a combination of ordered and non-ordered items will be denied as unprocessable.

GA, GZ, KX
For anti-reflective coating (V2750), tints (V2744, V2745) or oversized lenses (V2780), if medical necessity is documented by the treating physician, polycarbonate or Trivex TM lenses (V2784) the KX modifier must be added to the code.

For polycarbonate or Trivex TM lenses (V2784), if they are for a patient with monocular vision, the KX modifier must be added to the code.

The KX modifier may only be used when these requirements are met. When the KX modifier is billed, documentation to support the medical necessity of the lens feature must be available upon request. For anti-reflective coating (V2750), polycarbonate or Trivex TM lenses (V2784), tints (V2744, V2745) or oversized lenses (V2780), if the coverage criteria have not been met, the GA or GZ modifier must be added to the code.

When there is an expectation of a medical necessity denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claims lines for anti-reflective coating (V2750), tints (V2744, V2745), oversized lenses (V2780) or polycarbonate or Trivex TM lenses (V2784) billed without a KX, GA, or GZ modifier will be rejected.

RT, LT
The RT and/or LT modifiers must be used with all HCPCS codes in this policy except codes V2020, V2025 and V2600. When lenses are provided bilaterally and the same code is used for both lenses, bill both on the same claim line using the RTLT modifier and 2 units of service. Claims billed without modifiers RT and/or LT will be rejected as incorrect coding.

Common Claim Submission Errors
Some of the errors in the submission of claims is the lack of, or incorrect, information in the following sections of the CMS-1500 claim form or electronic equivalent:

Item 11 - If Medicare is the primary insurance, the word "None" should be entered.
Item 17 - The referring physician's name.
Item 17B - The referring physician's National Provider Identifier (NPI).
Item 21 - The appropriate ICD-9-CM diagnosis code must be used. The following are the covered ICD-9-CM codes for refractive lenses:

- V43.1 Pseudophakia
- 379.31 Aphakia
- 743.35 Congenital Aphakia

Item 24B - Place of service (POS) should be where the beneficiary is residing, not the office (POS 11). If the beneficiary resides at home, the POS would be 12. For a complete list of POS codes, please refer to Chapter 3 of our *Supplier Manual*.
Item 33 - Supplier name, address, telephone number.
Item 33A - Supplier National Provider Identifier (NPI).

First Quarter 2010 - Top Claim Submission Errors (GEN)

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 January through March 2010, are provided in the following table.

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 - Invalid Procedure Code and/or Modifier	210,590	The procedure code, modifier, or procedure code and modifier combination is invalid.
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	58,427	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	53,162	There is no link between the NPI that was submitted and a PTAN/NSC.
C095 - Diagnosis Code Invalid - Pointer 1	52,602	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	40,210	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C171 - Capped Rental - Modifier Missing	34,932	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.
B108 - Billing provider not authorized for submitter	28,929	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C143 - Ordering Provider ID Qualifier Invalid	28,649	The Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line.
C180 - Service Date Greater than Receipt Date	24,558	The service start/from date is greater than the date this claim was received.
C181 - Date of Service Invalid for Procedure	21,881	The HCPCS or NDC is not valid for the date of service. Check effective dates of HCPCS/NDC vs. dates of service on claim.

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the first quarter of 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 January through March 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.	27,261
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.	12,692
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,387
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.	2,595
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).	2,308
CO 16 N280 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid pay to provider primary identifier.	**Item 33** - NPI bypass logic rejection - Invalid NPI/PTAN (National Provider Identifier/Provider Transaction Access Number) pair on the crosswalk file.	1,459
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.	1,223
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.	864
CO 16 N257 Missing / incomplete / invalid billing provider/supplier primary identifier.	**Item 33** - Provider Transaction Access Number (PTAN) number submitted in error. Must submit National Provider Identifier (NPI).	719
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.	682

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!

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/**

Interactive ABN added to NHIC, Corp. DME MAC Web site (GEN)

The DME MAC A Outreach & Education Team has created an Interactive Advanced Beneficiary Notice of Noncoverage (ABN) Form (**http://www.medicarenhic.com/dme/online/Interactive_ABN_Form.pdf**).

This form provides a reference for proper completion of the ABN, to use the interactive form simply click on a section within the ABN Form and you will be taken to information on each particular section.

For additional information on the ABN refer to the Beneficiary Notices Initiative (BNI) (**http://www.cms.gov/BNI/02_ABN.asp#TopOfPage**) section of the CMS Web site.

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.

Top Incorrectly Answered Test Your Knowledge Quiz Questions

NHIC, Corp. DME MAC has analyzed the results from the most recent Test Your Knowledge Quizzes and identified the top 5 incorrectly answered questions from each of the following quizzes: KX, GA, GY and GZ modifier, Orthotic and Prosthetic, and Positive Airway Pressure (PAP) device.

The questions and answers are available in the Frequently Asked Question (FAQ) database (**http://www.medicarenhic.com/faq_results.asp?categories=DME**) for your reference.

Please be sure to check out our newest quizzes (**http://www.medicarenhic.com/dme/dme_quiz_index.shtml**) and Test Your Knowledge!

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 May of 2010 chapters 3 and 8 of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

Updating Supplier Records (GEN)

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

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

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

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

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

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

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

Written Inquiries

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

Written Inquiry FAX: 781-741-3118

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

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

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Redetermination Requests Fax: 781-741-3118

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

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

Faxed Reopenings: 781-741-3914

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:

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

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Mailing Address:

Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:

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

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Medical Review (MR) Requests for Additional Documentation (ADR) Responses

Mailing Address:

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

Via Fax:
781-741-3833

Physical Address for Overnight Mailings:

NHIC - DME MR ADS
75 William Terry Dr.
Hingham, MA 02044

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

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

DME MAC Jurisdiction A Resource

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

June 2010
Number 16

Publication Information

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

Visit the following websites for more information:

- NHIC, Corp.: 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:

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