DME MAC Jurisdiction A Resource

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

Table of Contents

March 2010
Number 15

Billing/Finance

General Information

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

NHIC, Corp.

TMP-EDO-0058 Ver. 2
03 / 08 / 2010

Table of Contents

Medical Review

Outreach & Education

Legend

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

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

April 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM6804) (DRU)

MLN Matters® Number: MM6804
Related CR Release Date: January 29, 2010
Related CR Transmittal #: R1899CP
Related Change Request (CR) #: 6804
Effective Date: April 1, 2010
Implementation Date: April 5, 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) 6804 which instructs Medicare contractors to download and implement the April 2010 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised January 2010, October 2009, July 2009, and April 2009 files. Medicare will use the April 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 April 5, 2010, with dates of service April 1, 2009, through June 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
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
April 2009 ASP and NOC files	April 1, 2009, through June 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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction (CR6804) issued to your Medicare MAC, carrier, and/or FI may be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1899CP.pdf** on the CMS website.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (MM6742) (GEN)

MLN Matters® Number: MM6742
Related CR Release Date: November 27, 2009
Related CR Transmittal #: R1862CP
Related Change Request (CR) #: 6742
Effective Date: January 1, 2010
Implementation Date: January 4, 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), Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed
CR 6742, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). The CR is effective January 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 coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year - in early March, July, and November although the Committee meets every month. A national code maintenance committee maintains the CARCs. That Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early 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 6742.

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

Additional Information
To see the official instruction (CR6742) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1862CP.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.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
232	Institutional transfer amount. Note: Applies to Institutional claims only and explains the DRG amount differences when patients care crosses multiple institutions.	11/1/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility - Must also include Remittance Advice Remark Code	11/1/2009

Modified Codes - CARC

Code	Current Modified Narrative	Effective Date Per WPC Posting
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance AdviceRemark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
107	Related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
152	Payer deems the information submitted does not support this length of service.	7/1/2010
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010

Code	Current Modified Narrative	Effective Date Per WPC Posting
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification (loop 2110 Service Payment Information REF), if present.	7/1/2010
16	Claim/service lacks information which is needed for adjudication. 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".)	7/1/2010
125	Submission/billing error(s). 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".)	7/1/2010
148	Information from another provider was not provided or was insufficient/incomplete. 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".)	7/1/2010
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided ((may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an "Alert".)	7/1/2010
A1	Claim/Service denied. 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".)	7/1/2010
40	Charges do not meet qualifications for emergent/urgent care. This change to be effective 07/01/2010: Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.	7/1/2010

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
87	Transfer Amount	1/1/2012
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility - Must also include Remittance Advice Remark Code	1/1/2012

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N521	Mismatch between the submitted provider information and the provider information stored in our system.	NO
N522	Duplicate of a claim processed as a crossover claim.	NO

Modified Codes - RARC:

Code	Modified Narrative	Medicare Initiated
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	NO
M118	Letter to follow containing further information.	NO
N59	Please refer to your provider manual for additional program and provider information.	NO
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	NO
N202	Additional information/explanation will be sent separately.	NO

Deactivated Codes - RARC

None

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

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

Note: *This article was rescinded on February 5, 2010, as the related CR 6528 was rescinded on February 4, 2010.*

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

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

Note: *This article has been replaced by article SE0930, which is available at* ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0930.pdf*** *on the Centers for Medicare & Medicaid Services website.*

Sunset of Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 for the Payment of Indian Health Services (IHS) (SE0930) (GEN)

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

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 is being 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 will no longer be covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, Congress is considering new legislation that may extend this provision beyond December 31, 2009. If such legislation is enacted, Medicare will notify contractors to again process claims for these IHS services.

These services 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.

Claims for services furnished on or before December 31, 2009, will be processed under normal conditions.

For services provided on or after January 1, 2010, health care providers may choose, to the extent possible, to hold their claims (that is, not submit their claims to Medicare) until it becomes clearer as to whether new legislation will be enacted to extend this provision. If legislation is enacted, claims submission for these items and services may resume. Otherwise, claims for these items and services, submitted with dates of service on or after January 1, 2010, will be denied because there would no longer be any statutory basis for such payment.

Depending on the effective date of possible legislation which extends coverage of these items and services, claims which were originally submitted and denied may be eligible for payment. If this has occurred, the submitter must contact the entity that processes their claims to have the claims adjusted. Affected providers need not resubmit their claims nor appeal the original denial.

CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue. Finally, be on the alert for possible action by Congress to extend this provision.

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: January 25, 2010
Related CR Transmittal #: R625OTN
Related Change Request (CR) #: 6566
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Note: *This article was revised on January 26, 2010, to reflect changes made to CR 6566 on January 25, 2010. The article was changed to reflect that the new edits apply to claims with dates of service on or after July 6, 2010. Code E0443 was added to the list of oxygen equipment and supply items in the table on page 4. Also, 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 **(Miami Only)**	Support Surfaces: Pressure Reducing Beds/Mattresses/Overlays/Pads	E0277, E0372, E0373, E0371, E0193
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.hhs.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.hhs.gov/Transmittals/downloads/R625OTN.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.hhs.gov/mlnmattersarticles/downloads/MM6282.pdf** on the CMS website.

Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010 (MM6792) (OXY)

MLN Matters® Number: MM6792
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R635OTN
Related Change Request (CR) #: 6792
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

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

What You Need to Know
CR 6792, from which this article is taken, announces instructions regarding payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010. Please see the Background section, below, for details.

Background
Section 1834(a)(5)(F)(ii)(III) of the Social Security Act provides for the payment of charges for reasonable and necessary maintenance of, and servicing of, oxygen equipment that you furnish after the 36-month rental payment cap for parts and labor that are not covered by the supplier's or manufacturer's warranty.

CR 6716, titled *Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008* and released November 2, 2009, provides instructions relating to the maintenance and servicing payments for oxygen equipment furnished through June 30, 2010. (You can find the related MLN Matters® Article at **http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6716.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.)

CR 6792, from which this article is taken, is a one-time notification that announces instructions regarding the payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010.

Specifically, CR 6792 provides that (effective for oxygen equipment, other than stationary or portable gaseous or liquid oxygen equipment, furnished on or after July 1, 2010) a maintenance and servicing fee of $66 is paid every 6 months, either beginning: 1) 6 months after the 36th paid rental month; or 2) when the item is no longer covered under the supplier's or manufacturer's warranty (whichever is later).

The maintenance and servicing fee, which will be updated annually through program instructions that are based on the covered item update for DME, covers all maintenance and servicing through the following 6 months that are needed in order to keep the oxygen equipment in good working order.

A single payment ($66 for dates of service July 1, 2010 through December 31, 2010) is made per beneficiary regardless of:

- The number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment);
- When the maintenance and servicing is performed during each 6-month period; or
- How often the equipment must be maintained and serviced.

You must make at least one maintenance/servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. For example:

- 36th monthly payment amount made for month ending July 31, 2010;
- 6-month period with no payment ends December 31, 2010;
- Maintenance and servicing payment may begin on January 1, 2011, provided warranty coverage ended on July 31, 2010, or earlier;
    - You must make at least one in-home visit during January 2011; and
    - Payment covers all maintenance and servicing through June 30, 2011.
- Second maintenance and servicing payment may be made on July 1, 2011;
    - You must make at least one in-home visit during July 2011, and
    - Payment covers all maintenance and servicing through December 31, 2011.

Note: *You will not receive payment for maintenance and servicing of gaseous or liquid oxygen equipment (stationary or portable), or for maintenance and servicing of beneficiary-owned oxygen equipment.*

Billing Guidance

You should use:

- Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E0433, or K0738 along with the MS modifier to bill and receive payment for maintenance and servicing of oxygen equipment other than gaseous or liquid oxygen equipment;
- HCPCS code E1390 for maintenance and servicing for a beneficiary using a single delivery port stationary oxygen concentrator or portable concentrator, and for maintenance and servicing for beneficiaries renting a combination of single delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code E1391 for maintenance and servicing for a beneficiary using a dual delivery port stationary oxygen concentrator or for beneficiaries renting a combination of dual delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code K0738 only in situations in which the beneficiary owns stationary oxygen equipment, but rents gaseous oxygen transfilling equipment; and
- HCPCS code E0433 only in situations in which the beneficiary owns stationary equipment but rents liquid oxygen transfilling equipment.

Notes: *1) Use HCPCS code E1390 (and not E1392) for maintenance and servicing of portable oxygen concentrator equipment; and 2) Bill the appropriate HCPCS code for the equipment or combination of equipment, as applicable, with the "MS" modifier.*

You should remember that only one maintenance and servicing payment can be made for any combination of oxygen equipment used by the beneficiary that is classified under HCPCS codes E1390, E1391, E1392, E0433 or K0738.

For example, if maintenance and servicing is billed for a column I code/modifier, additional payment for the maintenance and servicing of any of the column II codes/modifiers will not be made.

Column I	Column II
E1390MS	E1391MS, K0738MS, E0433MS
E1391MS	E1390MS, K0738MS, E0433MS
K0738MS	E1390MS, E1391MS, E0433MS
E0433MS	E1390MS, E1391MS, K0738MS

Further, the maintenance and servicing payments following the 36th month rental cap for oxygen concentrators and transfilling equipment terminate if the stationary oxygen equipment is replaced and a new 36-month rental period commences.

Finally, be aware that your RHHI, MAC, or DME MAC will deny your claims for the maintenance and servicing of beneficiary-owned oxygen equipment or equipment that you bill with HCPCS codes E0424, E0439, E0431, E0434, E1405, E1392 or E1406 and the "MS" modifier. They will also deny claims for more than one payment per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier.

When denying such claims, they will:

- Use the following remittance advice reason and remark codes:
  - Reason code A1: Claim/Service denied;
  - Remark Code M6 (revised) - Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
  - Remark Code N372: Only reasonable and necessary maintenance/service charges are covered.
- Assign group code CO (contractual obligation); and
- Use the following Medicare Summary Notice (MSN) messages for denied claims:
  - 8.28 - Maintenance, servicing, replacement, or repair of this item is not covered;
  - 16.35: You do not have to pay for this amount.

Additional Information
You can find more information about the maintenance and servicing payments for certain oxygen equipment after July 1, 2010 by going to CR 6792, located at **http://www.cms.hhs.gov/Transmittals/downloads/R635OTN.pdf** on the CMS website.

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

New Place of Service (POS) Code for Walk-in Retail Health Clinic (MM6752) (GEN)

MLN Matters® Number: MM6752
Related CR Release Date: December 11, 2009
Related CR Transmittal #: R1869CP
Related Change Request (CR) #: 6752
Effective Date: March 11, 2010
Implementation Date: March 11, 2010

Provider Types Affected
This article is for physicians; non-physician practitioners; Ambulatory Surgical Centers (ASC); Independent Diagnostic Testing Facilities (IDTFs); Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers; and Clinical Diagnostic Laboratories submitting claims to Medicare carriers, Parts A and B Medicare Administrative Contractors (A/B MACs) and DME MACs.

Provider Action Needed
This article, based on CR 6752, advises you that the current place of service (POS) code set has been updated to add a new code of 17 (Walk-in Retail Health Clinic). The code's description is as follows: "a walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services."

Note: For the health care industry, the HIPAA effective date of the new POS code for walk-in retail health clinics is no later than May 1, 2010, with covered entities permitted to use it at any time after which the new code is posted to the Centers for Medicare & Medicaid Services (CMS) POS webpage.

You need to know that Medicare has not identified a need for this new code. Therefore, you should continue to use the billing instructions for immunizations described in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.

Background
As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12 837 standards requires that each electronic claim transaction include a POS code from the POS code set maintained by CMS. As a payer, Medicare must be able to recognize as valid any valid code from the POS code set that appears on the HIPAA standard claim transaction. In accordance with HIPAA, Medicare will be able to recognize POS code 17 as valid by May 1, 2010, with plans to do so by March 11, 2010.

The new code 17 was established because industry entities other than Medicare identified a need to track the suppliers and settings of immunizations in greater detail than afforded through the current POS code set; these entities specifically wished to capture the walk-in retail health clinic, which they believe will be a common setting for immunizations.

Medicare has not identified a need for this new code, and physicians and other providers/suppliers are instructed to continue to use the billing instructions for immunizations described in the *Medicare Claims Processing Manual*, Chapter 18, Section 10.

Additional Information
The official instruction, CR 6752, issued to your carrier, A/B MAC, or DME MAC regarding this change, may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1869CP.pdf** on the CMS website. If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Reporting the Beneficiary's Residence State Code and ZIP Code for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Claims (MM6359) (GEN)

MLN Matters® Number: MM6359
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R634OTN
Related Change Request (CR) #: 6359
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected
This article is for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for DMEPOS services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on change request (CR) 6359 which states that, effective for claims processed on July 6, 2010 and later, the ZIP Code of the beneficiary's address of residence should be reported on the claim. Make certain your billing staffs are aware of this requirement.

Background
Currently, the Centers for Medicare & Medicaid Services (CMS) uses the beneficiary's address of residence to determine the applicable fee schedule amount for claims for DMEPOS items. When National Competitive Bidding (NCB) is fully implemented, the ZIP code of the beneficiary's address of residence, as reported on the claim, will also be used in pricing DMEPOS claims. If the beneficiary's ZIP code information is not available on the claim, the DME MACs will deny the claim using a reason code of 16 (Claims/Service lacks information which is needed for adjudication.) and remark code MA37 (Missing/incomplete/invalid patient's address).

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

The official instruction, CR6359, issued to your DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R634OTN.pdf** on the CMS website.

2010 Fees for Repairs (CR6720) (GEN)

Payment is allowed for reasonable and necessary repairs or nonroutine service of beneficiary-owned DMEPOS if not otherwise covered under an equipment warranty.

The below table identifies the 2010 fee schedule for K0739, L4205, L7520 for claims with dates of service from January 01, 2010, through December 31, 2010.

State	K0739	L4205	L7520
CT	22.40	20.45	27.14
DC	13.41	19.97	27.14
DE	24.71	19.97	27.14
MA	22.40	19.97	27.14
MD	13.41	19.97	27.14
ME	22.40	19.97	27.14
NH	14.40	19.97	27.14
NJ	18.10	19.97	27.14
NY	24.71	19.99	27.14
PA	14.40	20.56	27.14
RI	15.99	20.58	27.14
VT	14.40	19.97	27.14

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:

- 1st Quarter 2010 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 1st 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

The Medicare Learning Network Celebrates its 10th Anniversary (CMS Message 201001-11) (GEN)

The Medicare Learning Network - Celebrating 10 Years
As Your Medicare Educational Resource!

This year marks the 10th anniversary for the Medicare Learning Network (MLN) - the home for official information for Medicare Fee-For-Service providers. We're located within the Centers for Medicare & Medicaid Services (CMS) and over the past decade, we've been very busy:

- Producing quality educational products designed to meet the needs and learning styles of busy health care professionals;
- Adding continuing education credits to many of our online courses; and
- Developing new and different ways to make our products accessible and available to the FFS provider community.

Whether you're familiar with the Medicare Learning Network or just curious about us, our upcoming marketing campaign will help you to discover or re-discover the features and benefits that so many members of the FFS provider community turn to on a daily basis. So, check your e-mails and join us as we enter our second decade of dedication to providing the Medicare FFS provider community with the education and information resources it needs.

Learn More about the Medicare Learning Network Right Now!

Download the Medicare Learning Network Marketing Brochure
View our new Marketing Brochure (**http://www.cms.hhs.gov/MLNProducts/downloads/Medicare_Learning_Network_(MLN)_Marketing_Brochure.pdf**) online to learn what the Medicare Learning Network has to offer - print copies of this brochure will soon be available on our Product Ordering System.

Order The Medicare Learning Network DVD- A Good Place to Start
This DVD contains quick and basic information about the Medicare Learning Network and its benefits to providers. The DVD is suitable for self instruction, as well as exhibits and training events. National and local provider associations are encouraged to post this product on their websites and/or distribute via electronic newsletters or mailing lists. Run time is 7 minutes, 7 seconds.

Visit the Medicare Learning Network Product Ordering Page (**http://cms.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs**) and scroll down to the "Educational Tool" topic category to find the DVD and place your order. You can also view the video (**http://www.cms.hhs.gov/MLNGenInfo/Downloads/MLN_Long_Video.zip**) online.

Stay tuned for more!

Claim Status Category Code and Claim Status Code Update (MM6723) (GEN)

MLN Matters® Number: MM6723
Related CR Release Date: December 14, 2009
Related CR Transmittal #: R1874CP

Related Change Request (CR) #: 6723
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Note: *This article was revised on December 15, 2009, to reflect a revised CR 6723 that was issued on December 14. The CR release date, transmittal number, and the Web address for accessing CR 6723 were revised. All other information remains the same.*

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 CR6723, 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 September 2009 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on the Internet on November 1, 2009. All providers should ensure that their billing staffs are aware of the updated codes.

Background
The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. All code changes approved during the September 2009 committee meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on November 1, 2009. Medicare will implement those changes on January 4, 2010 as a result of CR6723.

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

The official instruction issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1874CP.pdf** 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: April 24, 2009
Related CR Transmittal #: R480OTN
Related Change Request (CR) #: 6421
Effective Dates: Phase 1 - October 1, 2009
Phase 2 - April 1, 2010
Implementation Date: Phase 1 - October 5, 2009
Phase 2 - April 5, 2010

NOTE: *This article was revised on December 11, 2009 to reflect an extension of phase 1 and a delay in implementing phase 2 of CR 6417. All other information remains the same.*

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-April 4, 2010):** If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. **If the ordering/referring provider is not in PECOS 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, (April 5, 2010 and thereafter):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS 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.hhs.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.hhs.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.hhs.gov/Transmittals/downloads/R480OTN.pdf** on the CMS website.

Expiration of Various Payment Provisions Under the Medicare Program (SE0931) (GEN)

MLN Matters® Number: SE0931
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: January 1, 2010
Implementation Date: January 1, 2010

Provider Types Affected
All Medicare providers should take note of this article.

Provider Action Needed
This special edition article is being issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected providers that a number of Medicare payment provisions, such as the Therapy Cap Exceptions Process and Allowing Independent Laboratories to Bill for the Technical Component of Physician Pathology Services Furnished to Hospital Patients, will no longer be in effect when the provisions sunset as of December 31, 2009.

CMS continues to work with Congress on significant legislation which affects the Medicare program. We believe some or all of these provisions may be extended as part of this legislation. We encourage you to monitor activity on the Hill and stay apprised of the status of potential legislation. In the meantime, if such legislation is enacted, Medicare will notify its contractors to again process claims consistent with the extended provisions.

Claims for services furnished on or before December 31, 2009, will be processed under normal conditions.

For services provided on or after January 1, 2010, health care providers may choose, to the extent possible, to hold their claims (that is, not submit their claims to Medicare) until it becomes clearer as to whether new legislation will be enacted to extend these provisions. If legislation is enacted, claims submission for affected services may resume. Otherwise, claims submitted with dates of service on or after January 1, 2010, will not be paid in accordance with expiring provisions because there would no longer be any statutory basis for such payment.

CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue. Finally, be on the alert for more information about this and other legislative provisions which may affect you.

Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Version 5010 276/277 Claim Status Second Phase (MM6721) (GEN)

MLN Matters® Number: MM6721 Revised
Related CR Release Date: January 15, 2010
Related CR Transmittal #: R623OTN

Related Change Request (CR) #: 6721
Effective Date: April 1, 2010 (except July 1, 2010 for Jurisdiction 9 MAC)
Implementation Date: April 5, 2010 (except July 6, 2010 for Jurisdiction 9 MAC)

Note: *This article was revised on January 19, 2010, to reflect a revised CR 6721 that was issued on January 15, 2010. The CR was revised to correct the definition of a data element (SVC07) in the 277 Flat File Standard attached to CR 6721. The corrected definition is in the attachment of the revised CR 6721. In this article, the CR release date, transmittal number, and the Web address for accessing CR 6721 have been changed. All other information remains the same.*

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (Carriers, Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries should be aware of this issue.

Provider Action Needed
This article is based on Change Request (CR) 6721 which provides technical directions to Medicare Shared System Maintainers and Medicare Contractors regarding the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 Version 005010 Health Care Claim Status Request and Response (276/277) transaction sets. Providers need to be aware of their own requirements to be fully compliant with the X12 5010 standards by January 1, 2012. Extensive information regarding the standards, along with helpful guidance for providers, is available at **http://www.cms.hhs.gov/Versions5010andD0/** on the Centers for Medicare & Medicaid Services (CMS) website. Note that the above implementation dates relate only to Medicare contractors completion of work on this particular phase of the implementation.

Background
Change Request (CR) 6721 provides technical direction to the following Medicare Shared System Maintainers and Medicare Contractors for implementing the second phase of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 for the Accredited Standards Committee (ASC) X12 Version 005010 Health Care Claim Status Request and Response (276/277) transaction sets. The CR also contains details on the Common Edits and Enhancement Module (CEM) software for the inbound Claim Status Inquiry process.

CMS has prepared a comparison of the current X12 HIPAA Electronic Data Interchange (EDI) standards (Version 4010/4010A1) with Version 5010 and the National Council for Prescription Drug Programs (NCPDP) EDI standards Version 5.1 to Version D.0. The 4010A1 Implementation Guides and the 5010 Technical Report 3 (TR3) documents served as reference materials during the preparation of the comparison excel spreadsheets. CMS is making the side-by-side comparison documents available for download in both Microsoft Excel and PDF formats. The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain this product for purposes other than Medicare Fee-for-Service. You can find these documents at **http://www.cms.hhs.gov/MFFS5010D0/20_Technical%20Documentation.asp#TopOfPage** on the CMS website.

Additional Information
The official instruction, CR 6721, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R623OTN.pdf** on the CMS website.

You can also review the Final Rule as published in the Federal Register on January 16, 2009 by the Department of Health and Human Services 45 CFR Part 162, Subpart N-Health Care Claim Status at **http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf** on the Internet.

You can find more information about HIPAA Version 5010 and NCPDP Version D.0. at **http://www.cms.hhs.gov/ElectronicBillingEDITrans/18_5010D0.asp** on the CMS website. A special edition MLN Matters® article, SE0832, on the ICD-10 code set is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf** on the CMS website.

Instructions on How to Process Negative Claim Adjustment Reason Code (CARC) Adjustment Amounts when Certain CARCs Appear on Medicare Secondary Payer Claims (MM6736) (GEN)

MLN Matters® Number: MM6736
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R73MSP
Related Change Request (CR) #: 6736
Effective Date: July 1, 2010
Implementation Date: July 6, 2010

Provider Types Affected
This article applies to all physicians, providers, and suppliers submitting 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 provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 6736, which provides Medicare contractors with processing instructions for claim adjustment reason code (CARC) adjustment amounts that are negative when certain CARCs appear on incoming Medicare Secondary Payer (MSP) claims.

You should know that Medicare contractors will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive Claim Adjustment Segment (CAS) CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as a negative adjustment. Please be sure your billing staffs are aware of these changes.

Background
CRs 6426 and 6427 instruct Medicare contractors to take into consideration the CARCs and the applicable adjustment amounts when processing MSP claims. Business requirements (BRs) 6426.6 and 6427.6 instruct shared systems to add certain CARC adjustment amounts to the paid amounts when these CARCs are received on a claim. There have been rare circumstances where the CARCs found in BR 6426.6 and 6427.6 on incoming MSP claims include a negative adjustment amount and the shared systems mistakenly added the same adjustment amount to the claim based on instructions found in CR 6426 and 6427.

CR 6736 provides instructs Medicare contractors not to add the CARCs when the adjustment amounts on incoming MSP claims are negative. Medicare systems will automatically reprocess any MSP claims retroactive to July 5, 2009, and remove the positive CAS CARC adjustment from the primary payer payment amount where a CARC adjustment was added to the primary payer payment amount when the same CAS CARC adjustment was received as negative adjustment.

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

CR 6426 is available at **http://www.cms.hhs.gov/transmittals/downloads/R70MSP.pdf** on the CMS website. CR 6427 is available at **http://www.cms.hhs.gov/transmittals/downloads/R67MSP.pdf** on the CMS website.

The official instruction, CR 6736, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R73MSP.pdf** on the CMS website. CR 6736 includes the revisions that will be made to the *Medicare Secondary Payer (MSP) Manual*, Chapter 5 (Contractor Prepayment Processing Requirements), Section 40.7.5, Effect of Failure to File Proper Claim, as an attachment to that CR.

Interim Instructions for Processing Claims and Recouping Overpayments for Claims Submitted Under the Guidelines Established in Change Request 5917 (MM6762) (GEN)

MLN Matters® Number: MM6762
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R636OTN
Related Change Request (CR) #: 6762
Effective Date: May 5, 2010
Implementation Date: May 5, 2010

Provider Types Affected
This article is for physicians, producers, and suppliers billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain durable medical equipment (DME) products provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 6762 which provides instructions to Medicare contractors for recouping funds for any payments made to durable medical equipment prosthetics, orthotics and supplies (DMEPOS) suppliers for implanted DME or implanted prosthetics, based on the revised list of HCPCS codes payable as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME provided in CR 6573. Medicare contractors will continue to pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME based on the supplier's location. (See CR 6573 for the revised list of HCPCS codes at **http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf** that may be paid as replacement part, accessory or supply for prosthetic implants and surgically implanted DME under the guidelines established in CR 5917.) Be sure billing staff are aware of these Medicare changes.

Background
The Centers for Medicare & Medicaid Services (CMS) issued CR 6762 in order to augment previously issued CR 6573. CR 6573 instructed contractors to use the revised list to determine the items that may be billed under the guidelines established in CR 5917 which may be reviewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1603CP.pdf** at on the CMS website.

CR 6573 clarified that the filing jurisdiction for claims submitted under the guidelines established in CR 5917 is determined by the supplier's location and that the payment for these items is based on the fee schedule amount for the State where the beneficiary maintains their permanent residence.

In CR 5917, CMS instructed Medicare contractors to process and pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME when submitted by suppliers that are enrolled with both the National Supplier Clearinghouse (NSC) and their local carrier/A/B MAC.

Although CR 5917 reinstated the local carrier and A/B MAC jurisdiction for claims for these items, the **instruction was not clear about the claims filing jurisdiction or the payment rules that apply when the beneficiary resides outside of the local carrier or A/B MAC's jurisdiction.** In addition, Attachment A of CR 5917 included an excerpt of the 2008 annual jurisdiction list containing Healthcare Common Procedure Coding System (HCPCS) codes, which CMS previously instructed may be billed to the carrier or A/B MAC as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME. It has since come to CMS' attention that this **list included codes for implanted devices, which may not be separately billed** to the carrier/A/B MAC by DMEPOS suppliers. Attachment A of CR 5917 was replaced by a revised list of HCPCS codes in Attachment A of CR 6573. The web links to CR 5917 and CR 6573 are listed above.

Key Points of CR 6762

- Medicare contractors will pay claims for items subject to the guidelines in CR 5917 based on the supplier's location per the revised list of HCPCS codes included in Attachment A of CR 6573.

- To the extent possible, Medicare contractors will reopen and reprocess claims for implanted DME and or implanted prosthetics for dates of service between October 27, 2008, and December 31, 2009 and they will recoup any overpayments made to DMEPOS suppliers for implanted DME or implanted prosthetics based on using the original list of HCPCS codes included in Attachment A of CR 5917.

- CR 6762 and the billing guidelines for replacement parts, accessories or supplies for implanted devices established in CR 5917 **apply only to DMEPOS suppliers enrolled with the NSC and their local carrier or A/B MAC** and does not change the existing carrier or A/B MAC billing rules that apply to physicians, facilities, or other entities that are implanting the devices.

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

The official instruction, CR6762, issued to your MAC or carrier regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R636OTN.pdf** on the CMS website.

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

To review MM6573, the MLN Matters® article related to CR 6573, go to **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6573.pdf** on the CMS website.

Medicare Systems Edit Refinements Related to Hospice Services (MM6778) (GEN)

MLN Matters® Number: MM6778
Related CR Release Date: February 5, 2010
Related CR Transmittal #: R121BP and R1907CP

Related Change Request (CR) #: 6778
Effective Date: Claims submitted on or after July 6, 2010
Implementation Date: July 6, 2010

Provider Types Affected
Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries that have elected the hospice benefit.

Provider Action Needed
This article is based on Change Request (CR) 6778 which:

1. Revises existing Medicare standard systems edits to **allow Medicare fee for service (FFS) claims to process for beneficiaries in a Medicare Advantage plan on the date of a Medicare hospice election.**
2. Adds new edits ensuring the **appropriate place of service is reported for hospice general inpatient care (GIP), respite, and continuous home care (CHC); and**
3. **Provides a technical correction to the *Medicare Benefit Policy Manual* regarding the requirement for nursing care related to hospice continuous home care.**

Be certain your billing staffs are aware of these Medicare changes.

Background
Claims for Medicare Advantage (MA) Plan Beneficiaries Electing Hospice
In an effort to alleviate the often timely process involved for providers to resolve claim disputes on payment responsibility between MA plans and FFS Medicare, The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare hospice and MA enrollment edit(s) for claims submitted on or after July 6, 2010 to allow claims to be processed by FFS Medicare for services occurring on the date of the hospice election. This will prevent services provided on the date of the election from rejecting as MA Plan responsibility. Providers that have claims being disputed may resubmit their claims on or after July 6, 2010 to FFS Medicare for payment consideration. Contractors will not be required to provide automated adjustments.

Place of Service for General inpatient care (GIP, Respite, and Continuous Home Care CHC
Medicare hospice patients are able to receive hospice care in a variety of settings. CMS began collecting additional data on hospice claims in January 2007 with CR 5245, available at **http://www.cms.hhs.gov/transmittals/Downloads/R1011CP.pdf**, which required reporting of a Healthcare Common Procedure Coding System (HCPCS) code on the claim to describe the location where services are provided. Coverage and payment regulations at 42 CFR 418.202 and 418.302 define the locations where certain levels of care can be provided. GIP is described in the regulations at 42 CFR 418.202(e) as "short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or skilled nursing facility (SNF)..." Additionally, the regulations at 42 CFR 418.202(e) require that respite care be furnished in an inpatient setting, as described in 418.108, which limits care settings to a participating Medicare or Medicaid hospital, SNF, hospice facility, or nursing facility (NF). Finally, payment regulations at 42 CFR 418.302(a)(2) define CHC as "a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home." Because CMS now has site-of-service data on hospice claims, they are able to use system edits to ensure more accurate billing of Medicare claims. CMS now edits claims to ensure that the level of care billed, for hospice, was provided at an appropriate site.

To facilitate more accurate billing of Medicare hospice claims, CMS is implementing several edits within the claims processing system to return to providers (RTP), claims submitted on types of bill 81x or 82x for which hospice days are billed for services provided in non-covered settings. Claims for days of GIP care (revenue code 0656) will be RTP'd if HCPCS site of service locations Q5001 (patient's home/residence), Q5002 (assisted living facility), or Q5003 (nursing long term care facility of non-skilled nursing facility) are reported on the same line, as these are not appropriate settings for payment of GIP. GIP may only be provided at Medicare certified hospice facilities, hospitals, or SNFs.

Similarly, claims for respite days (revenue code 0655) will be RTP'd if HCPCS site of service codes Q5001 (patient's home/residence) or Q5002 (assisted living facility) are reported on the same line, as these are not appropriate settings for payment of this level of care. Respite care may only be provided in a Medicare or Medicaid participating hospital, SNF, hospice facility, or NF.

Finally, claims for days of CHC care (revenue code 0652) will be RTP'd if HCPCS site of service locations Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5006 (inpatient hospice), Q5007 (long term care hospital), or Q5008 (inpatient psychiatric facility) are reported on the same line, as these locations are not appropriate settings to bill for payment of CHC. CHC may only be provided in the patient's home, and may not be provided in these types of facilities. We believe these edits will improve the accuracy of Medicare billing and payment for hospice services.

Technical Correction

Regulations at 42 CFR 418.204 describe CHC as being provided during periods of crisis as necessary to maintain an individual at home. The regulation requires that care provided on days billed as CHC be "predominantly nursing care". This means that more than half of the time the nurse, aide, or homemaker spends providing care must be nursing hours.

Manual Clarification Regarding Ambulance Transport on the Date of Hospice Election

CR 6778 also revises the *Medicare Benefit Policy Manual* to clarify policy regarding payment of ambulance transports on the effective date of hospice election. Hospices do not feel that they are responsible for an ambulance transport which occurs on the effective date of hospice election, if the hospice has not yet conducted their initial assessment.

The deciding factor in determining whether a hospice is financially responsible for an ambulance transport on the effective day of hospice election is when the transport occurred, relative to when all the hospice coverage and eligibility criteria are met. If an ambulance transport occurs on the date of hospice election, but before all the criteria for hospice eligibility and coverage are met (i.e. the initial assessment has been conducted and the plan of care has been developed and includes the ambulance transport), the hospice is not responsible for the transport and the ambulance transport is covered through the ambulance benefit.

Additional Information

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

The official instruction, CR6778, was issued to your MAC, carrier, RHHI or FI regarding this change via two transmittals. The first, located at **http://www.cms.hhs.gov/Transmittals/downloads/R121BP.pdf**, contains revisions to the *Medicare Benefit Policy Manual*. The second transmittal at **http://www.cms.hhs.gov/Transmittals/downloads/R1907CP.pdf** contains revisions to the *Medicare Claims Processing Manual*.

MM5245, *Instructions for Reporting Hospice Services in Greater Line Item Detail*, is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf** on the CMS website. For additional information regarding the Hospice Payment System see **http://www.cms.hhs.gov/MLNProducts/downloads/hospice_pay_sys_fs.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.

Revision of Definition of Compendia as Authoritative Source for Use in the Determination of a Medically-Accepted Indication of Drugs/Biologicals Used Off-label in Anti-Cancer Chemotherapeutic Regimens (MM6806) (DRU)

MLN Matters® Number: MM6806 Revised
Related CR Release Date: January 29, 2010
Related CR Transmittal #: R120BP
Related Change Request (CR) #: 6806
Effective Date: January 1, 2010
Implementation Date: March 1, 2010

Note: *This article was revised on February 17, 2010, to include Web links to additional information regarding this issue.*

Provider Types Affected
This article is for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FI), Part A/B Medicare Administrative Contractors (A/B MAC), or DME Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know
CR 6806, from which this article is taken, announces that effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen). This revision requires a publicly transparent process for evaluating therapies and for identifying potential conflicts of interest. Please see the Background section, below, for details.

Background
A compendium is defined "as a comprehensive listing of FDA-approved drugs and biologicals (or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment)."

Section 1861(t)(2)(B)(ii)(I) of the Social Security Act (the Act), as amended by section 6001(f)(1) of the Deficit Reduction Act of 2005, Pub. Law 109-171, recognizes three compendia: 1) American Medical Association Drug Evaluations (AMA-DE); 2) United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and 3) American Hospital Formulary Service-Drug Information (AHFS-DI). To date, AHFS-DI, plus other authoritative compendia (found at **http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp#TopOfPage**) that the Secretary of Health and Human Services identifies, serve as sources for you to use in determining the "medically-accepted indication" of drugs and biologicals that are used off-label in an anti-cancer chemotherapeutic regimen (*unless the Secretary has determined that the use is not medically appropriate or the use is identified as not indicated in one or more such compendia*).

In the Medicare Physician Fee Schedule final rule for calendar year 2008, CMS established a process for revising the list of compendia, and also increased the transparency of the process by incorporating a list of desirable compendium characteristics outlined by the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) on March 30, 2006, as criteria for decision-making.

Although the MEDCAC desirable characteristics for compendia included reference to conflict of interest and transparency, section 182(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) amended Section 1861(t)(2)(B) of the Act by adding the following new sentence: "On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests."

CR 6806, from which this article is taken, announces that effective January 1, 2010, CMS is revising the definition of "compendium" in the *Medicare Benefit Policy Manual*, Chapter 15, Section 50.4.5 to include this public transparency requirement.

In this revised definition, a compendium:

1. Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases;
2. Is indexed by drug or biological; and
3. Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Additional Information
You can find more information about the revised definition of "compendium" by going to CR 6806, located at **http://www.cms.hhs.gov/Transmittals/downloads/R120BP.pdf** on the CMS website.

For more detailed information about the revised definition of "compendium" and the incorporation of MIPPA section 182 (b) into the compendia review process for current and future statutorily recognized compendia based on this provision, see Issues Related to MIPPA Number 13. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen released in the November 25, 2009 Federal Register, which you can find at **http://www.gpo.gov/fdsys/pkg/FR-2009-11-25/pdf/E9-26502.pdf** on the Internet.

You will find this revised compendium definition in the updated *Medicare Benefit Policy Manual*, chapter 15, (Covered Medical and Other Health Services), Section 50.4.5 (Process for Amending the List of Compendia for Determinations of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen) as an attachment to that CR.

You might also want to read the MLN Matters® article titled Compendia as Authoritative Sources for Use in the Determination of a "Medically Accepted Indication" of Drugs and Biologicals Used Off-Label in an Anti-Cancer Chemotherapeutic Regimen, released on October 24, 2008, which you can find at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6191.pdf** on the CMS website.

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

Medicare's DMEPOS Competitive Bidding Program - A Better Way for Medicare to Pay for Medical Equipment (SE1007) (GEN)

MLN Matters® Number: SE1007
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters® article is informational for physicians, providers, and suppliers submitting claims to the Medicare Program. The article provides an overview of and the rationale for Medicare's Competitive Bidding Program for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) being implemented by the Centers for Medicare & Medicaid Services (CMS).

What You Need to Know
Medicare's Competitive Bidding Program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is an important step towards paying appropriately for medical items and services. The program will **reduce** out-of-pocket expenses for Medicare beneficiaries and **save** the Medicare program money while ensuring beneficiaries continue to receive **quality** products from **accredited** suppliers.

Background
Examples of DMEPOS include oxygen equipment, walkers, wheelchairs, devices used to treat sleep disorders, and hospital beds. Medicare generally pays 80 percent of the "fee schedule" payment amount for DMEPOS items used in the home by beneficiaries under Part B of Original Medicare, and beneficiaries pay the remaining 20 percent. For most of these items, the "fee schedule" payment amounts are based on historical charges, adjusted for inflation at times, and not on current market prices. Numerous studies by the Office of the Inspector General and the Government Accountability Office have found that the prices paid by Medicare for certain DMEPOS items are excessive --- sometimes three or four times retail prices and the amounts paid by commercial insurers. Clearly, Medicare needs a better way to pay for DMEPOS items.

Under the DMEPOS Competitive Bidding Program, Medicare beneficiaries with Original Medicare who live in competitive bidding areas (CBAs) will pay less for certain DMEPOS items and services. DMEPOS suppliers compete to become Medicare contract

suppliers by submitting bids to furnish certain medical equipment and supplies in the CBAs. Medicare will use these bids to set a "single payment amount," which will replace the "fee schedule" amount as payment for those items. The "single payment amount" must be lower than the "fee schedule amount." All suppliers are thoroughly screened to make sure they meet Medicare requirements before they are awarded contracts. In certain situations, beneficiaries in CBAs who rent oxygen or certain other durable medical equipment may continue renting these items from their current suppliers when the program takes effect, regardless of whether the supplier is a contract supplier. Beneficiaries who start using competitive bid DMEPOS items after the program begins or who do not continue renting equipment from their current suppliers will need to use contract suppliers in most cases.

Competitive bidding:

- Creates incentives for suppliers to continue to provide quality products and services efficiently and at a reasonable cost.
- Lowers the costs to beneficiaries and to taxpayers. Once fully implemented across the country, total savings are projected to be in the billions of dollars each year.
- Requires that all suppliers in the program meet strict quality and financial standards and be accredited by a Medicare-deemed national accreditation organization.
- Selects multiple winning contract suppliers, both small and large, to ensure beneficiaries have access to quality medical equipment and supplies with a choice of suppliers.

Proven Results

Competitive bidding for DMEPOS is proven to save money for taxpayers and Medicare beneficiaries while maintaining access to quality DMEPOS items and services. The *Balanced Budget Act of 1997* required Medicare to test competitive bidding for DMEPOS items as a new way to set fees. Medicare implemented two demonstration projects in Polk County, Florida and San Antonio, Texas to determine if competitive bidding among suppliers would be successful in driving down costs to a fair market value while maintaining product quality. The demonstration projects showed that competition helps Medicare beneficiaries receive quality medical equipment and supplies at fair and reasonable prices. At the completion of the demonstration projects in 2002, Medicare found that:

- 77 percent of winning bidders were small suppliers;
- Beneficiaries saved 20 percent through the competitive model;
- Access to quality equipment and supplies was maintained; and
- Beneficiary satisfaction remained high.

Implementation Overview

After the successful demonstrations, the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA) mandated that Medicare phase in the DMEPOS Competitive Bidding Program. Round One of the program was implemented on July 1, 2008 in 10 CBAs and resulted in a projected average savings of 26 percent compared to Medicare's fee schedule amounts. Two weeks after implementation, Congress enacted a temporary delay of the program as part of the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) which mandated certain program modifications but did not fundamentally change the nature of the program required by the MMA.

The MIPPA required CMS to terminate supplier contracts awarded in Round One and to conduct a new competition in nine CBAs in 2009. Together with its Competitive Bidding Implementation Contractor, Medicare is currently evaluating bids suppliers submitted in 2009 and expects to announce the competitive bidding payment rates **resulting from the competition** in June 2010. Medicare plans to announce the contract suppliers in September 2010, and the program is scheduled to go into effect in the nine Round One Rebid areas on January 1, 2011. Medicare will begin the supplier competition for the next phase (Round Two) of the program in 2011.

Round One Rebid Areas and Product Categories

The Round One Rebid Areas are:

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

The Round One Rebid Product Categories are:

- Oxygen supplies and equipment;
- Standard power wheelchairs, scooters, and related accessories;
- Complex rehabilitative power wheelchairs and related accessories (Group 2 only);
- Mail-order diabetic supplies;
- Enteral nutrients, equipment, and supplies;
- Continuous Positive Airway Pressure (CPAP) machines and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beds and related accessories;
- Walkers and related accessories; and
- Support surfaces (Group 2 mattresses and overlays in Miami only).

Additional Information

To learn more about Medicare's DMEPOS Competitive Bidding Program, visit **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/** and **http://www.cms.hhs.gov/Partnerships/03_DMEPOS_Toolkit.asp#TopOfPage** on the CMS website.

Providers Randomly Selected to Participate in the Medicare Contractor Provider Satisfaction Survey (MCPSS) Urged to Respond (SE1005) (GEN)

MLN Matters Number: SE1005
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

Medicare fee-for-service (FFS) physicians, providers, suppliers, and other health care practitioners that received a letter indicating they were randomly selected to participate in the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS) should review this article.

Provider Action Needed

This Special Edition article alerts providers that the Centers for Medicare & Medicaid Services (CMS) has launched the fifth annual national administration of the MCPSS. If you received a letter indicating 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 your FFS contractor. Survey questionnaires can also be submitted by mail, secure fax, and over the telephone.

Background

CMS is responsible for the administration of the FFS Medicare program and does so primarily through its Medicare FFS contractors. As Medicare's agents, these contractors are responsible for executing the daily operational aspects of the FFS Medicare program by processing and paying the more than $370 billion in Medicare claims each year and performing other related business functions that support regular daily interactions with Medicare FFS providers.

The MCPSS that is conducted annually by CMS is designed to collect quantifiable data on provider satisfaction with the performance of Medicare FFS contractors. The MCPSS offers Medicare FFS providers an opportunity to give CMS valuable feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. Survey questions focus on seven key business functions of the provider-contractor relationship:

- Provider Inquires
- Provider Outreach & Education
- Claims Processing
- Appeals
- Provider Enrollment

- Medical Review
- Provider Audit & Reimbursement

The MCPSS is a result of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which mandated CMS to develop contract performance requirements, including measuring health care provider satisfaction with Medicare contractors. The MCPSS enables CMS to hear provider concerns, monitor trends, improve contractor oversight, and increase efficiency of the Medicare program. The MCPSS provides contractors with more insight into their provider communities and allows them to make process improvements based on provider feedback.

The 2010 MCPSS Study

Sample Selection

Each year, a new random sample of Medicare FFS providers is selected to participate in the MCPSS. For the 2010 MCPSS study, CMS will ask approximately 30,000 Medicare FFS providers and suppliers to participate in the MCPSS. The sample is scientifically designed, and then randomly selected, to represent the community of more than 1.5 million Medicare providers nationwide who serve Medicare beneficiaries across the country. The sample includes Medicare FFS physicians, limited licensed practitioners (LLP), labs, hospitals, skilled nursing facilities (SNF), rural health clinics (RHC), home health agencies (HHA), federally qualified health centers (FQHC), hospice facilities, end-stage renal disease (ESRD) facilities, durable medical equipment (DME) suppliers, ambulance service providers, and other Part A institutional facilities and Part B health care practitioners. Those health care providers randomly selected to participate in the 2010 MCPSS were notified in January.

Web-based Survey Questionnaire

CMS continues to make completing and returning the survey simple by migrating to an easy to use Web-based survey. Providers selected to participate in the 2010 study will have access to an online Web-based survey tool where they can rate their contractor's performance and complete and submit their survey questionnaire over a secure Internet website. The Internet is a quick, convenient, and environmentally friendly way for providers to contribute directly to CMS' understanding of contractor performance. CMS encourages all participants with Internet access to submit their completed survey online. Participants may also submit their completed survey questionnaire via mail, secure fax, and over the telephone. The 2010 MCPSS takes approximately 20 minutes to complete.

New Satisfaction Rating Scale

The 2010 survey questions use a fully-labeled five-point Likert response scale with "1" representing "Very Dissatisfied" and "5" representing "Very Satisfied". In contrast to previous years' surveys which used a six-point scale, where only the end-points were labeled, this new scale assigns words to every answer category and includes a neutral category. The change will allow CMS to communicate a well-defined message about the performance of the Medicare contractors. While only health care providers selected to participate in the 2010 MCPSS may complete and return the survey questionnaire, a **sample** of the 2010 MCPSS questionnaire is available for viewing at **http://www.cms.hhs.gov/mcpss** for informational purposes.

Reporting Results

CMS will analyze the 2010 MCPSS data and release a summary report on the CMS website in the summer of 2010. The report prepared for this study will summarize findings across the sample and will not associate responses with a specific individual, practice, or facility. CMS has contracted with SciMetrika, a public health consulting firm, to administer this important survey and report statistical data to CMS.

Provider Participation Key to Success of Study

Participation in the MCPSS is voluntary, however, the survey offers providers the opportunity to contribute directly to CMS' understanding of Medicare contractor performance, as well as aid future process improvement efforts at the contractor level. The views of every health care provider asked to participate in the 2010 study are very important to the success of this study, as each one represents many other organizations that are similar in size, practice type, and geographical location.

The feedback captured through the MCPSS is important. CMS urges all providers selected to participate in the 2010 study to take this opportunity to provide CMS with their feedback on the performance of the Medicare FFS contractor that processes and pays their Medicare claims. CMS requests that you complete your survey questionnaire as quickly as possible when you receive it.

CMS is listening and wants to hear from you.

Additional Information
For more information about the MCPSS, including results of the 2009 MCPSS, please visit **http://www.cms.hhs.gov/mcpss** on the CMS website.

CMS Manual System
Pub 100-20 One-Time Notification
Transmittal 617

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Date: January 8, 2010
Change Request 6712

Transmittal 178, Change Request 5402, dated December 8, 2006, is being rescinded and replaced with Transmittal 617. This change request replaces the file format and some of the process and is denying FISS lines; and updates how CMS handles modifier 55. All other material remains the same.

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: 617	Date: January 8, 2010	Change Request 6712

Transmittal 178, Change Request 5402, dated December 8, 2006, is being rescinded and replaced with Transmittal 617. This change request replaces the file format and some of the process and is denying FISS lines; and updates how CMS handles modifier 55. All other material remains the same.

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.hhs.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 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				
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							

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	
6712.4	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				
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 and ANSI reason code XX, Payment denied/reduced because the payer deems the information submitted exceeds the number of medically likely services, 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				

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	
6712.12	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.	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			
6712.15	Contractors shall refer providers to the Web site: "**http://www.cms.hhs.gov/ National CorrectCodInitEd/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	DME RC	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:

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.hhs.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

CMS News Flash (GEN)

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

Flu Season is upon us! CMS encourages providers to begin taking advantage of each office visit to encourage your patients with Medicare to get a seasonal flu shot; it's their best defense against combating seasonal flu this season. (Medicare beneficiaries may receive the seasonal influenza vaccine without incurring any out-of-pocket costs. No deductible or copayment/coinsurance applies.) For more information about Medicare's coverage of the seasonal influenza vaccine and its administration as well as related educational resources for health care professionals, please go to **http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp** on the CMS website.

H1N1 - Medicare will cover immunizations for H1N1 influenza also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. For more information, go to **http://www.cms.hhs.gov/H1N1** on the CMS website.

MCPSS - 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 **http://www.cms.hhs.gov/mcpss** or read the CMS Special Edition MLN Matters article, SE1005, located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1005.pdf** on the CMS website.

MCPSS - The Centers for Medicare & Medicaid Services (CMS) is listening and wants to hear from you about the services provided by your Medicare Fee-for-Service (FFS) contractor that processes and pays your Medicare claims. CMS is preparing to conduct the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider Inquiries, Provider Outreach & Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement. The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate in the 2010 MCPSS will be notified starting in January. If you are selected to participate, please take a few minutes to complete this important survey. Providers and suppliers can complete the survey on the Internet via a secure website or by mail, fax, or telephone. To learn more about the MCPSS, please visit **http://www.cms.hhs.gov/MCPSS** on the CMS website.

Electronic Health Record (EHR) Technology - The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) encourage public comment on two regulations issued on 12/30/2009 that lay a foundation for improving quality, efficiency and safety through meaningful use of certified electronic health record (EHR) technology. CMS and ONC worked closely to develop the two rules and received input from hundreds of technical subject matters experts, health

care providers, and other key stakeholders. The CMS proposed rule and related fact sheets may be viewed at **http://www.cms.hhs.gov/Recovery/11_HealthIT.asp** on the CMS website. The ONC's interim final rule may be viewed at **http://healthit.hhs.gov/standardsandcertification** on the Internet.

National Provider Identifier (NPI) - 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.hhs.gov/MedicareProviderSupEnroll** and clicking on "Ordering/Referring Report" on the left-hand side.

Are you wondering how to find the latest and greatest Medicare resources by subject? The ***REVISED Guided Pathways (November 2009) booklets*** incorporate existing Medicare Learning Network (MLN) products and other resources into well organized sections that can help Medicare Fee-for-Service (FFS) providers and suppliers find information to understand and navigate the Medicare Program. These booklets guide learners to Medicare program resources, FFS policies and requirements. You can access the ***REVISED Guided Pathways (November 2009) booklets*** at **http://www.cms.hhs.gov/MLNEdWebGuide/30_Guided_Pathways.asp** on the Medicare Learning Network.

Quick reference charts can be handy lists for looking up information! The Medicare Learning Network (MLN) has produced two **QUICK REFERENCE CHARTS,** which provide information on frequently used CMS web pages. The ***Quick Reference: All Medicare Providers (DEC2009) chart*** includes a list of CMS web pages that ALL Medicare providers use most frequently. The ***Quick Reference: New Medicare Provider (DEC2009) chart*** includes a list of CMS web pages that NEW Medicare providers use most frequently. These charts can be bookmarked and viewed online or they can be printed and used as ready references. Both charts can be located at **http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp** on the MLN Publications page. Use search key word "quick" to locate these publications.

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

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

LCD and Policy Article Revisions - Summary for January 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.

Ankle Foot/Knee Ankle Foot Orthosis

LCD
Revision Effective Date: 01/01/2010
HCPCS CODES AND MODIFIERS:
Added: A4466
Deleted: L1901
Revised Description: L4396

Policy Article
Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information for code A4466.
CODING GUIDELINES:
Deleted: Reference to invalid code L2770.

Ostomy Supplies

LCD
Revision Effective Date: 01/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Requirements concerning request for refill.
HCPCS CODES AND MODIFIERS:
Deleted: A4365
Added: A4456

Policy Article
Revision Effective Date: 01/01/2010
Relocated: Faceplate Column I Column II table
ICD-9 CODES THAT ARE NOT COVERED:
Deleted: A4365
Added: A4456

Respiratory Assist Devices

LCD
Revision Effective Date: 02/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: Term “progressive” from general coverage criteria of neuromuscular diseases.
Moved: Definitions contained in section III to the GENERAL section with the other definitions.
Changed: Term “usual” to “prescribed” in the descriptor for FIO2 testing throughout.

Added: Early coverage criteria for E0471 to COPD section.
Moved: Late coverage criteria for E0471 to COPD section from CONTINUED COVERAGE section.
Removed requirement to rule out CPAP (criteria B).
Added: Hypoventilation Syndrome as a covered indication.
Removed: Medicare Beneficiary Statement requirement.
Added: Supply/accessory quantity monitoring requirement.

DOCUMENTATION REQUIREMENTS:

Removed: Beneficiary Statement requirements.

Surgical Dressings

LCD

Revision Effective Date: 01/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: A6200-A6202 from composite dressing reference.
Clarified: Usual dressing changes for gauze with zinc paste.

HCPCS CODES AND MODIFIERS:

Deleted: A6200, A6201, A6202, A6542, A6543

Policy Article

Revision Effective Date: 01/01/2010

CODING GUIDELINES:

Deleted: References to A6200, A6201, A6202

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

LCD and Policy Article Revisions - Summary for January 28 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.

Knee Orthoses

LCD

Revision Effective Date: 01/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Coverage criteria for L1810, L1820
Added: Definition for knee instability
Revised: Coverage criteria for L1832

HCPCS CODES AND MODIFIERS:

Deleted: L1800, L1815, L1825
Added: A4466

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Revised: Covered diagnoses for L1832

Policy Article

Revision Effective Date: 01/01/2010

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Reference to code A4466

CODING GUIDELINES:

Deleted: Definitions for L1800, L1815, and L1825
Deleted: Reference to code L2770

Positive Airway Pressure Devices

LCD

Revision Effective Date: 01/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: PAP device coverage when based on facility-based PSG - coverage based on date of PSG not DOS of device for credentialing requirement.

Power Mobility Devices

LCD

Revision Effective Date: 10/01/2009 (January 2010 Revision)

DOCUMENTATION REQUIREMENTS:

Revised: Wording of one element of the detailed product description

Wheelchair Options and Accessories

LCD

Revision Effective Date: 04/01/2010

HCPCS CODES AND MODIFIERS:

Added: GA, GZ

Deleted: E2223, E2393, E2399 (effective 01/01/2010)

DOCUMENTATION REQUIREMENTS:

Revised: Requirements for the detailed product description

Added: Instructions for use of the GA, GY, and GZ modifiers

Revised: Requirements for use of the KX modifier

Policy Article

Revision Effective Date: 01/01/2010

CODING GUIDELINES:

Revised: Changed references from code E2399 to K0108

Deleted: References to codes E2223, E2393

Wheelchair Seating

LCD

Revision Effective Date: 04/01/2010

HCPCS CODES AND MODIFIERS:

Added: GY

Revised: GA

DOCUMENTATION REQUIREMENTS:

Added: Requirements for use of the GY modifier

Revised: Requirements for detailed product description

Revised: Requirements for use of the KX modifier

Revised: Requirements for use of GA and GZ modifiers

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

LCD and Policy Article Revisions - Summary for February 4, 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 Infusion Pumps

LCD

Revision Effective Date: 04/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Physician assessment interval for insulin pumps from every 6 months to every 3 months.

HCPCS CODES AND MODIFIERS:

Added: GA and GZ modifiers.

Revised: KX modifier.

DOCUMENTATION REQUIREMENTS:

Removed: KX modifier requirement for supplies billed with external insulin infusion pumps and insulin.

Revised: Requirements for use of KX modifier with external insulin infusion pumps and insulin to meet either the C-Peptide level criteria or beta cell autoantibody criterion.

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

Added: Instructions for use of GY modifier from Policy article to LCD.

Facial Prostheses

LCD

Revision Effective Date: 01/01/2010

HCPCS CODES AND MODIFIERS:

Replaced: A4365 with A4456.

Policy Article

Revision Effective Date: 01/01/2010

CODING GUIDELINES:

Replaced: A4365 with A4456.

Nebulizers

LCD

Revision Effective Date: 01/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Replaced: Q4080 with Q4074 in the Iloprost coverage indications.

HCPCS CODES AND MODIFIERS:

Replaced: Q4080 with Q4074

ICD-9 CODES:

Replaced: Q4080 with Q4074 in the ICD-9 requirements.

DOCUMENTATION REQUIREMENTS:

Replaced: Q4080 with Q4074 in the KX, GA and GZ modifiers requirements.

Policy Article

Revision Effective Date: 01/01/2010

CODING GUIDELINES:

Replaced: Q4080 with Q4074 in the Inhalation Drug Requirements.

Deleted: J7649 and J7659 from the Inhalation Drug Requirements.

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

Policy Article

Revision Effective Date: 01/01/2010

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Changed: Timing in criterion 4 to match IOM 100-02, Chapter 15, Section 50-5-4.

ICD-9 CODES THAT ARE COVERED:

Deleted: V58.0-V58.12 and replaced with V58.11 to match IOM 100-02, Chapter 15, Section 50-5-4.

Spinal Orthoses

LCD

Revision Effective Date: 01/01/2010

HCPCS CODES AND MODIFIERS:

Added: A4466

Deleted: GY

DOCUMENTATION REQUIREMENTS:

Deleted: Use of GY modifier with elastic spinal orthoses (Refer to Policy Article for coding guidelines for elastic and nonelastic spinal orthoses.)

Policy Article

Revision Effective Date: 01/01/2010

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Revised code reference (A4466) for elastic spinal orthoses.

CODING GUIDELINES:

Added: Instructions for coding elastic and nonelastic flexible spinal orthoses.

Added: Requirement for Coding Verification Review effective 07/01/2010.

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

LCD and Policy Article Revisions - Summary for February 19, 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.

Immunosuppressive Drugs

LCD

Revision Effective Date: 04/01/2010

HCPCS CODES AND MODIFIERS:

Revised: KX modifier.

DOCUMENTATION REQUIREMENTS:

Added: Requirement that beneficiary was enrolled in Medicare Part A at time of the transplant.

Policy Article

Revision Effective Date: 4/01/2010

CODING GUIDELINES:

Changed: SADMERC to PDAC.

Pressure Reducing Support Surfaces - Group 2

LCD

Revision Effective Date: 04/01/2010

HCPCS CODES AND MODIFIERS:

Added: GA and GZ modifiers.

Revised: KX modifiers.

DOCUMENTATION REQUIREMENTS:

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

Pressure Reducing Support Surfaces - Group 3

LCD

Revision Effective Date: 04/01/2010

HCPCS CODES AND MODIFIERS:

Added: GA and GZ modifiers.

Revised: KX modifier.

DOCUMENTATION REQUIREMENTS:

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

Urological Supplies

LCD

Revision Effective Date: 01/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Coverage statement for urethral inserts.

Added: Statement about refilling orders.

HCPCS CODES AND MODIFIERS:

Added: A4336, A4360, A4456

Policy Article

Revision Effective Date: 01/01/2010

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: A4360 to list of statutorily excluded items.

CODING GUIDELINES:

Replaced: A4365 with A4456

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

LCD and Policy Article Revisions - Summary for February 25, 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.

Lower Limb Prosthesis

LCD

Revision Effective Date: 01/01/2010

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Functional level requirement for L5973.

HCPCS CODES AND MODIFIERS:

Added: L5973

DOCUMENTATION REQUIREMENTS:

Deleted: Outdated instruction for code L5930.

Policy Article

Revision Effective Date: 04/01/2010

CODING GUIDELINES:

Revised: Instructions for use of code L7520.

Deleted: Instructions for use of RP modifier.

Revised: Instructions for use of ultralight component codes L5940-L5960.

Added: Statement concerning rejection of claims without an RT or LT modifier.

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 01/01/2010
HCPCS CODES AND MODIFIERS:
Added: E0433
Revised: E0441-E0444

Policy Article

Revision Effective Date: 01/01/2010
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Coverage for maintenance and servicing, months 37-60.
CODING GUIDELINES:
Deleted: Instructions for codes E0441-E0444
Added: E0433

Patient Lifts

LCD

Revision Effective Date: 04/01/2010
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: E1036
HCPCS CODES AND MODIFIERS:
Revised: KX modifier.
Added: GA and GZ modifiers.
Added: E1036 (effective 01/01/2010)
Revised: E1035
DOCUMENTATION REQUIREMENTS:
Added: KX modifier requirement for E1036.
Added: GA and GZ modifier instructions.

Policy Article

Revision Effective Date: 01/01/2010
CODING GUIDELINES:
Added: E1036 to E1035 definition.
Added: E1036 to list of codes that require PDAC coding review.

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

Automatic External Defibrillators - Coverage Reminder (SPE)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have recently become aware of marketing material which suggests that coverage for a wearable automatic external defibrillator (AED) (K0606) is available immediately following a myocardial infarction and in several clinical situations that are not specified in the LCD. Reimbursement is available only under the criteria listed in the LCD.

Wearable AEDs (K0606) are covered as an alternative to implanted defibrillators when criteria specified in the *Automatic External Defibrillator Local Coverage Determination* (LCD) are met. Wearable AEDs are covered for patients if they meet one of the following criteria:

1. A documented episode of ventricular fibrillation or a sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia. These dysrhythmias may be either spontaneous or induced during an electrophysiologic (EP) study, but may not be due to a transient or reversible cause and not occur during the first 48 hours of an acute myocardial infarction (ICD-9 427.1, 427.42, 427.5); or

2. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmia's such as long QT syndrome (ICD-9 426.82) or hypertrophic cardiomyopathy (ICD-9 425.1); or
3. Either documented prior myocardial infarction (ICD-9 410.00-410.92, 412) or dilated cardiomyopathy (ICD -9 425.0-425.9) and a measured left ventricular ejection fraction less than or equal to 0.35; or
4. A previously implanted defibrillator now requires explantation (ICD-9 996.04, 996.61)

Nonwearable AEDs (E0617) have different coverage criteria. Refer to the LCD for additional information.

E0118 - Crutch Substitute (MOB)

Section 1862 of the Social Security Act requires that an item or service must be "reasonable and necessary" before payment may be made. A reasonable and necessary determination is largely based on a review of the published clinical literature that is relevant to the item under consideration. When there is no published policy for an item, contractors may still make individual determinations when reviewing claims.

The Jurisdiction A DME MAC has received questions concerning coverage of HCPCS code E0118.

E0118 - Crutch substitute, lower leg platform, with or without wheels, each

The DME MAC medical directors have reviewed information about the products billed using this code. The determination is that there is insufficient published clinical literature demonstrating safety and effectiveness in the Medicare population to establish the medical necessity for these products.

Medical literature supporting coverage of these items can be submitted to: Paul Hughes, M.D., Medical Director, DME MAC - Jurisdiction A, 75 Sgt. William Terry Drive, Hingham, MA 02043

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

Mobility Assistive Equipment - Contradictory Equipment - Coverage Reminder (MOB)

Medicare does not reimburse for durable medical equipment (DME) with contradictory coverage requirements. Contradictory coverage occurs when meeting the coverage requirements for an item makes coverage ineligible for another item with differing criteria, resulting in claim denials. This scenario often occurs within the group of DME items addressed in the CMS National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE).

The MAE NCD sets coverage for a diverse group of products including canes, crutches, walkers, manual and power wheelchairs and power operated vehicles. Coverage is provided for mobility assistive equipment for,

> "…beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations within the home".
> (IOM 100-3 §280.3)

While this fundamental coverage statement is applicable to all MAE items, additional criteria are present for each type of item. The NCD describes the application of these additional criteria,

> "Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit".
> (IOM 100-3 §280.3)

The algorithm is guided by a series of nearly 40 questions set out in the NCD. These questions are designed to assess which type of equipment is most appropriate to address the beneficiary's mobility deficit(s). Further, the application of an algorithmic approach precludes the use of differing items at the same time. For example, if a cane is sufficient to meet the mobility needs, there is no need for a walker or a wheelchair at that same time. Claims for these items will be denied.

Medicare does recognize that medical conditions progress over time and equipment needs may change, e.g., a beneficiary with a walker may no longer be able to ambulate and thus need a wheelchair. The medical record should contain detailed information about the change in medical condition that justified the need for different equipment. This information must be available upon request by the DME MAC.

A number of related resources are available from the following sources

- *Medicare NCD Manual*, Chapter 1, Part 4, Section 280.3 - Mobility Assistive Equipment
- CMS MAE Web site

- Applicable DME MAC Local Coverage Determinations
- DME MAC Supplier Manual

Pneumatic Compression Devices - Article Retired (SPE)

The December 2005 article "**Coverage of E0652 Pneumatic Compression Device**" published by TriCenturion is being retired effective December 19, 2005. The article contains examples of scenarios for which an E0652 device would be reimbursed i.e. painful focal lesions, scars, etc. These examples are incorrect. They were originally present in the CMS national coverage policy effective in 1995, but were removed in a 2003 revision. They should not have been included in this 2005 article. The Local Coverage Determination (LCD) for Pneumatic Compression Devices was revised, removing the examples at the time of the national policy revision.

When an article is retired its provisions are no longer in effect as of the date of the retirement. In this case, since the article contained incorrect information as of the publication date, the retirement date is set as the same date.

Remember that coverage criteria for items are published in National and Local Coverage Determinations. Articles do not establish coverage criteria. They may only be used to explain or clarify policy material.

Refer to the LCD for additional information regarding reimbursement for pneumatic compression devices.

Positive Airway Pressure (PAP) Devices LCD Revision - January 2010 (SPE)

The Positive Airway Pressure (PAP) Devices local coverage determination (LCD) has been revised, effective for dates of service (DOS) on or after January 01, 2010. The revision addresses physician credentialing and the interpretation of facility-based polysomnograms (PSG). The current policy requirement is based on the date of service the PAP device is dispensed. The revised policy requirement is based on the date of service of the facility-based polysomnogram. The consequences of this change are illustrated in the scenarios below:

Polysomnogram date: November 15, 2009 by a non-credentialed physician
PAP device initial DOS: January 15, 2010

Current Policy
Policy requires that for PAP devices with DOS on or after January 01, 2010, interpreting physician must meet credentialing requirements. PAP device would be denied since DOS for PAP claim is after 01/01/2010.

Revised Policy
Policy requires that physicians interpreting facility-based PSGs performed on or after January 01, 2010 must be credentialed. PAP device allowed since date of test is prior to effective date of 01/01/2010 for credentialing requirement.

Suppliers are encouraged to read the entire LCD and policy article for additional coverage, coding and documentation guidance.

Urological Supplies - Physician Letter - February 19, 2010 (SPE)

Dear Physician,

In 2008 Medicare changed the local coverage determination (LCD) for urological supplies. The previous policy covered "clean technique" for patients without a history of recurring urinary tract infections - allowing four intermittent catheters per month which were cleaned and re-used. The new policy allows any patient who utilizes intermittent catheterization to receive one sterile urological catheter and one packet of lubricant for each catheterization.

There are a couple of important points to keep in mind when ordering urological supplies for your patients. First, the prescription should reflect the actual number of times that the patient actually catheterizes him/herself per day. For example, if the patient self-catheterizes four times per day, the prescription should be for approximately 120 catheters per month. Although the LCD says that Medicare will cover up to 200 intermittent catheters per month, this is a maximum number and most patients self-catheterize less than 6 times per day. It would be inappropriate to order 200 catheters per month for every patient. The prescription must be individualized for each patient.

The second important point is that you should clearly document in your chart the number of times per day that the patient performs self-catheterization. Just listing that value on the prescription or on a separate form provided by the supplier is not sufficient. In the case of an audit, we would look for documentation in the patient's medical record.

Thank you for your cooperation and your care of Medicare beneficiaries.

Paul J. Hughes, MD
Medical Director, DME MAC Jurisdiction A

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

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

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

Surgical Dressings - Billing Update (GEN)

Our current review of claims for Surgical Dressings by the DME MAC Jurisdiction A, Medical Review, identified billing discrepancies regarding the correct use of modifiers A1 to A9 with surgical dressing claims.

The use of these modifiers is required. Suppliers must always use the appropriate modifier based on the number of wounds being treated. For example, when billing for A6216 (gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing), if one wound is being treated, modifier A1 should be used. For two wounds, modifier A2 should be appended to the HCPCS, etc. Our determination of the correct units of service will be based on the modifier billed.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the LCD and policy article. Suppliers can review these on our web site at: **http://www.medicarenhic.com/dme**

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

DME MAC A will be initiating a widespread prepayment Probe of claims for "Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate" (E1390), "Portable gaseous oxygen system, rental: includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing" (E0431), and "Stationary liquid oxygen system, rental includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing" (E0439). This review is being initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) contractor.

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

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

- Documentation of dispensing order (if item is dispensed based on a verbal order)
- Detailed written order (must include liters per minute)
- Payable diagnosis
- Copy of initial qualifying arterial blood gas (ABG) or pulse oximetry report referenced on the CMN
- Initial Certificate of Medical Necessity (CMS Form 484) (CMN may act as substitute for written order *if it is sufficiently detailed*)
- Documentation of initial in-person evaluation
- Re-certification CMN if applicable
- Copy of recertification qualifying arterial blood gas (ABG) or pulse oximetry report referenced on the CMN (if applicable)
- Documentation of an in-person recertification evaluation (if applicable)
- Beneficiary authorization
- Proof of delivery
- Medical record information from treating physician to support that beneficiary is continuing to require, use and benefit from oxygen therapy equipment

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

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

---

Widespread Prepayment Probe for A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Tracheostomy) (L11536) (GEN)

DME MAC A will be initiating a widespread prepayment probe of claims for **Tracheostomy, Inner Cannula (A4623) and Tracheostomy Care Kit for Established Tracheostomy (A4629)**. This review is being initiated due to a high volume of claims.

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

Documentation should include the following per the Tracheostomy Care Supplies (L11536) LCD:

- Physician's written orders
- Medical records that contain information about the items used and/or the underlying medical condition
- Delivery ticket with name, address and signature of beneficiary and supply provided
- Invoice including manufacturer name and model number
- Any other pertinent documentation that would support the medical necessity of the item billed

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

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy article. Suppliers can review the *Tracheostomy Care Supplies (L11536) LCD* on the NHIC Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

---

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

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly widespread pre-payment probe review findings. The previous quarterly findings covered the period from July 01, 2009 through September 30, 2009 and resulted in a 87.27% Charge Denial Rate (CDR).

DME MAC A recently concluded a quarterly pre-payment review. The results of the quarterly review for claims paid from October 01, 2009 through December 31, 2009, identified the following:

- This review involved prepayment complex medical review of 80 claims submitted by 59 suppliers, of which, 24 claims were allowed and 66 were denied resulting in a claim denial percentage of (70%). Consequently, the total denied allowance amount (dollar amount of allowable charges for services determined billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 72.086%.

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

- Determined to be medically unnecessary (46.4%) (examples).
  - Face to Face; not a physical exam; did not address mobility issue; not signed by physician.
  - Upper extremity / lower extremity issues not addressed or ROM and strength indicated did not justify PWD.
  - Functional limitations not addressed in the face-to-face evaluation.
  - Incomplete 7 element order (not all 7 elements indicated).
- Forms determined to be supplier generated pre-printed forms (16.1%) (examples).
  - Prescription / 7 element partially supplier completed.
  - Mobility Evaluation supplier formatted check off list.
  - Face to Face supplier formatted questionnaire, not a comprehensive examination.
- Incomplete documentation (33.9%) (examples).
  - No 7 elements / prescription, no face to face evaluation, no product description signed by the physician submitted.
  - Mobility evaluation not signed.
  - No HCPCS codes and / or no allowances.
  - Supplier did not date stamp receipt of the prescription.

To justify the removal of a pre-payment edit, the error rate must reflect a reduction of 70 percent or more. Based on the above quarterly 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**.

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.

Documentation Reminder - Order Requirements (GEN)

Data analysis by the Redeterminations area has identified several compliance issues associated with orders submitted to the DME MAC. Order requirements are discussed in several manuals and many Local Coverage Determinations. It is important to remember that all items billed to Medicare require an order before providing the item. Orders are categorized into three types: dispensing orders, detailed written orders and written orders prior to delivery.

Dispensing Orders
Suppliers may dispense most items of DMEPOS based on a verbal order or preliminary written order from the treating physician. Dispensing orders must include the following:

- Beneficiary's name
- Start date of the order
- Description of the item
- Physician's name

For items that are dispensed based on a verbal order or preliminary written order, the supplier must obtain a detailed written order that meets the requirements of the "Detailed Written Order" section below. Suppliers must maintain records of the preliminary written order or written documentation of the verbal order. This documentation must be available upon request.

Detailed Written Orders
Detailed written orders are required for all transactions involving DMEPOS. Detailed written orders may take the form of a photocopy, facsimile image, electronically maintained, or original "pen-and-ink" document.

All orders must clearly specify the start date of the order.

If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information regarding:

- Quantity used
- Frequency of change
- Duration of need

The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description or a brand name/model number.

If the supply is a drug, the order must specify the name of the drug, concentration (if applicable), dosage, frequency of administration, and duration of infusion (if applicable).

Someone other than the physician may complete the detailed description of the item; however, the treating physician must review the detailed description and personally sign and date the order to indicate agreement. Signature stamps are not acceptable. The supplier must have a detailed written order prior to submitting a claim. Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.) is NOT in itself considered to be part of the order although it may be put on the same document as the order.

Written Order Prior to Delivery
A detailed written order prior to delivery is required for:

- Pressure reducing pads, mattress overlays, mattresses, and beds
- Seat lift mechanisms
- TENS units
- Power operated vehicles and power wheelchairs

For the above items, the supplier must have received a written order that has been both signed and dated by the treating physician and meets the requirements of a detailed written order (see previous "Detailed Written Order" section) before dispensing the item.

For additional information regarding orders, reference the following resources:

- The *DME MAC A Supplier Manual*, Chapter 10 **http://www.medicarenhic.com/dme/suppmandownload.shtml**

- CMS *Medicare Program Integrity Manual* - Publication 100-8, Chapter 5
  http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf

Utilizing the Interactive Voice Response System to Check for Same/Similar DMEPOS Items (GEN)

During the intake process, and prior to dispensing or delivering the item, suppliers should ask the beneficiary if they have purchased or are currently renting the same or similar equipment, from another supplier. Additionally, suppliers should evaluate the patient's Medicare claims payment history to determine if there is record of the beneficiary's purchase or rental of same or similar equipment. If the patient's Medicare claims payment history reveals that the same or similar equipment was previously purchased or rented, suppliers should then determine what happened to the equipment previously purchased or rented by the beneficiary (i.e., was the equipment lost, stolen, irreparably damaged, etc.)

Suppliers may also utilize the Vips Provider Inquiry (VPIQ) system to determine if same/similar items are on file within the contractor's files, or suppliers may use the interactive voice response (IVR) system to check for same or similar HCPCS codes on file locally within the Jurisdiction A records or within the Common Working File (CWF). Suppliers may obtain the information through the IVR by selecting the same or similar option from the main menu, which is option 7. The same or similar option only provides information on base codes, not related accessories or drugs. For example, if a beneficiary has a manual wheelchair (K0001) and leg rests (K0195), the same or similar option only provides equipment that is same or similar for the K0001. No information will be given on the K0195. The Certificate of Medical Necessity option is still available which can give accessories and/or drugs related to a base code, which is option 3 from the main menu. Although some items do not require a CMN, the IVR system can still search for same or similar items if the item is classified as a capped rental item, frequent and substantially serviced item, an inexpensive and routinely purchased item, or if the item requires a CMN or Durable Medical Equipment Information Form (DIF).

For prosthetics, orthotics, and supplies, **the beneficiary must provide verbal authorization to a customer service representative (CSR) to release protected health information to the supplier or other healthcare representative**. Items in the prosthetic, orthotic, and supplies categories include the following:

- Diabetic supplies
- Therapeutic shoes
- Ankle/foot orthosis
- Knee orthosis
- Cervical traction devices
- External breast prosthesis
- Eye prosthesis
- Facial prosthesis
- Lower limb prosthesis
- Orthopedic footwear
- Refractive lenses
- Ostomy supplies
- Tracheostomy supplies
- Surgical dressings
- Urological supplies

If a beneficiary wishes to provide verbal authorization, the supplier must contact a customer service representative at 866-590-6731 ***with the beneficiary on the line*** and meet the applicable disclosure requirements.

For additional requirements regarding disclosure of beneficiary specific information please refer Chapter 2, Section 30 of CMS IOM Pub. 100-04, *Medicare Contractor Beneficiary and Provider Communications Manual*, **http://www.cms.hhs.gov/manuals/downloads/com109c02.pdf**.

It is the supplier's responsibility to be aware of the reasonable useful lifetime provisions for the items they routinely bill. If the patient has the same or similar piece of equipment in their Medicare claim payment history and the item has not reached its reasonable useful lifetime period, claims billed for the same or similar item will deny. Same/similar equipment denials are considered medical necessity

denials and over utilization of services being billed. Although the item is not denied based on the local coverage determination, the claim is denied as unreasonable and necessary due to the existence of same or similar equipment in the patient's history. Therefore, suppliers may execute an ABN if there is reason to believe that an item or service may be denied as not medically necessary due to the patient having a same or similar piece of equipment. If an ABN is not properly executed and the claim denies suppliers are required to refund the beneficiary.

Note: *Suppliers are liable for CO denials. However, if the beneficiary chooses to obtain an item even though he or she already owns or rents the same or similar item, and the beneficiary accepts financial liability by signing the ABN, a PR denial will be issued assigning liability to the beneficiary.*

If a supplier believes a claim has been incorrectly denied for same/similar equipment, they should submit a request for redetermination.

Redetermination requests should be submitted to:

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

Requests to Change Liability (Addition of GA Modifier)

A note from Redeterminations:

A Redetermination must be requested for liability changes on previously denied claims. This includes claims that have been denied with a medical necessity or same/similar contractual obligation (CO) denial and the supplier is requesting the addition of the GA modifier to receive a patient responsibility (PR) denial. Claims rejected (**CO-4**) for the absence of the KX, GA, GY or GZ modifiers must still be corrected and resubmitted. For change of liability appeals requests, suppliers must complete the CMS-20027 (**http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf**) and must submit a copy of the Advance Beneficiary Notice of NonCoverage (ABN). The ABN will be reviewed and validated prior to the requested change being completed. Requests received on Reopening forms will not be accepted as redeterminations. Additional information on the appeals process is available in Chapter 8 of the DME MAC A Supplier Manual (**http://www.medicarenhic.com/dme/suppmandownload.shtml**). Specific information regarding the appeal rights for supplier liable claims is located in Chapter 30, section 30.2.2, of Pub. 100-4, Medicare Claims Processing Manual, **http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf**

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

Fourth Quarter 2009 - Top Claim Submission Errors (GEN)

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

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 - Invalid Procedure Code and/or Modifier	219,762	The procedure code, modifier, or procedure code and modifier combination is invalid.
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	60,322	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).
C095 - Diagnosis Code Invalid - Pointer 1	58,575	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
C003 - Billing NPI Not Found on Crosswalk	55,512	There is no link between the NPI that was submitted and a PTAN/NSC.
C044 - Subscriber Primary ID Invalid	41,243	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C143 - Ordering Provider ID Qualifier Invalid	36,038	The Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line.
C171 - Capped Rental - Modifier Missing	35,978	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	31,949	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C096 - Diagnosis Code Invalid - Pointer 2	23,620	The diagnosis code pointed to by diagnosis code pointer 2 is invalid for the claim line date of service.
C046 - Diagnosis Code 2 Invalid for Date of Service (DOS)	23,285	The second diagnosis code is not pointed to by any claim line and the effective dates of the diagnosis code falls entirely outside the claim's date of service.

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 fourth quarter of 2009. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

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

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	15,837
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.	13,452
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	2,414
CO 16 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.	2,073
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).	1,887
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.	1,715
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.	1,321
CO 16 N286 Missing / incomplete / invalid referring provider primary identifier.	**Item 17A** - Physician UPIN (Unique Physician Identifier Number) submitted in error. Physician NPI must be submitted in Item 17B.	1,207
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	1,120
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.	984

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!

Attention All Providers: Reduce Duplicate Denials (GEN)

The Jurisdiction A Outreach & Education Team conducted an analysis of all claims denied between the period of January - September 2009 to determine the volume of unnecessary duplicate denials. Claims denied as a duplicate (CO-18) represented approximately 9% of all denied claims during this time frame.

CO-18 indicates a claim has been submitted for the same beneficiary, service and date of service as a previously adjudicated (processed) claim. The processing of unnecessary duplicate claims causes additional workload and expense for the DME MAC, the provider community and the over-all Medicare Program. To prevent this from occurring, the claim has to be given an adequate amount of time for adjudication before re-submitting the item for processing. For example, billing systems should not be set-up to automatically bill for

the same beneficiary, service and date of service on a weekly or bi-weekly basis until the claim is paid or denied. Claim processing requirements for the DME MAC are to complete claims within 30 days of receipt.

Claims denied in full or individual claim lines denied with a duplicate denial (CO-18) should not be re-submitted. Claims or claim lines should also not be re-submitted when denied with a medical necessity denial (CO-50), or a same/similar denial. These claims should be appealed or reopened, as appropriate.

DME MAC A will continue to monitor the submission of duplicate claims to identify submitters (clearinghouses, billing services, providers, etc.) who have a negative impact on the volume of unnecessary duplicate claim denials. The Outreach & Education Team will then determine the most appropriate means of education and/or follow-up action to reduce this volume.

We ask that you do your part to assist in this mission. Be sure your billing systems are set-up appropriately and claims are submitted per Medicare Program and DME MAC instruction.

PECOS Dear Physician Letter (GEN)

Dear Physician:

CMS is expanding claim edits for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics and Supplies.

Effective, January 03, 2011, Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEPOS) suppliers will not receive payment from Medicare for items that you ordered if you do not have a current enrollment in the Medicare Provider Enrollment, Chain and Ownership System (PECOS). This could result in your patient not receiving the item or being held financially liable. Help your DMEPOS supplier continue to provide quality service to your patients by promptly enrolling in PECOS, or update your Medicare enrollment if you haven't done so recently.

For any DMEPOS item to be covered by Medicare, it must be ordered by a physician or a practitioner who is **eligible** to order such items. **Physicians or practitioners must be enrolled in PECOS** and must be indicated in the system as specialty eligible to order **DMEPOS items** for Medicare beneficiaries.

The providers who can order DMEPOS items include -
Doctor of:

- Medicine or Osteopathy
- Dental Medicine or Dental Surgery
- Podiatric Medicine
- Physician Assistant
- Certified Clinical Nurse Specialist
- Nurse Practitioner
- Optometry

In order to continue to order DMEPOS for Medicare beneficiaries, you will have to enroll in the Medicare program or "revalidate" your Medicare enrollment information. You may do so by:

- Using Internet-based PECOS (be sure to mail the signed and dated Certification Statement to the carrier or A/B MAC immediately after submitting the application), or
- By filling out the appropriate Medicare provider enrollment application(s) and mailing it, along with any required information, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment application.

To confirm if you have a current enrollment record in Medicare, contact your designated enrollment contractor or you can go on-line, using Internet-based PECOS, to view your enrollment record. While doing so, if you have a PECOS record, ensure that your NPI is in it. If it is not, update your enrollment record.

For additional information regarding PECOS refer to: **http://www.cms.hhs.gov/MedicareProviderSupEnroll**

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

March 2010 National Supplier Clearinghouse (NSC) Newsletter Now Available (GEN)

The NSC recently announced the availability of the March 2010 NSC Newsletter. This edition features information on Competitive Bidding, reporting changes in ownership, submitting corrective action plans, an excerpt from MLN Matters 6566 providing guidance on implementing system edits for certain DMEPOS, and much more. To access the details, click on the following link: **http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/837RJ96652?opendocument**

DME MAC A ListServes (GEN)

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

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

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

Quarterly Provider Update (GEN)

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

Supplier Manual News (GEN)

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

Updates/Corrections Made:
In an effort to increase efficiency and convenience for our users the DME *MAC A Supplier Manual* is now available as one complete PDF document. Previously the *Supplier Manual* was available as separate documents for each chapter, which required the opening of 13 individual files to view the entire manual. Now as one complete file, **the entire *Supplier Manual* is only one click away**.

Additional benefits to having the entire ***Supplier Manual*** in one file include:

- **Search the entire document at once** - By using the "Find" Feature in Adobe Acrobat (Ctrl+F) users can now search the entire *Supplier Manual* at one time.
- **Interactive Table of Contents** - There is now a fully clickable Table of Contents at the beginning of the document allowing users to navigate to their desired section in a single click.
- **Revision History** - New to the *Supplier Manual* is a Revision History located at the end of the document. It is no longer necessary to compare the new and old versions to discover what has changed.

In February of 2010 chapters 2, 3, 4, 9, 10 and 12 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.

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

For Your Notes

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

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

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

March 2010
Number 15

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.hhs.gov/

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

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

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

NHIC, Corp.
A CMS Contractor

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