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

September 2010
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Billing/Finance

General Information

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Table of Contents

Medical Review

Outreach & Education

Registration is Open for the

2010 DME MAC Jurisdiction A Symposiums

For more information visit:

http://www.medicarenhic.com/dme/symposium/Symposium_General_Information.shtml

Legend

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

Clarification of the Date of Service for Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010 (MM6990) (OXY)

MLN Matters® Number: MM6990
Related CR Release Date: June 8, 2010
Related CR Transmittal #: R717OTN
Related Change Request (CR) #: 6990
Effective Date: July 1, 2010
Implementation Date: July 9, 2010

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

What You Need to Know
CR 6990, from which this article is taken, clarifies (effective July 1, 2010) the date of service (DOS) of an oxygen equipment maintenance and servicing visit as discussed in CR 6792 (Maintenance and Servicing Payments for Certain Oxygen Equipment After July 1, 2010).

In particular, please note one element of this clarification, i.e., CR 6990 requires that the applicable date of Service (DOS) must be at least 6 months after the 36-month rental cap for oxygen equipment or the end of the warranty period for maintenance and servicing, **whichever is later. Further, before a supplier can bill for maintenance and servicing, the supplier must verify and document in their records that the oxygen equipment is no longer covered under a warranty and the supplier must visit the beneficiary's home to inspect the equipment.**

Please see the background section, below, for additional information; and you should make sure that your billing staffs are aware of these clarifications.

Background
CR 6792 (released on February 5, 2010) announced (for dates of service on or after July 1, 2010) that Medicare regulation 42 CFR 414.210(e) (5) permits one payment for all maintenance and servicing of certain oxygen equipment during each 6-month period, beginning 6 months after the end of the 36-month rental period for oxygen equipment. (You can find the associated MLN Matters® article at **http://www.cms.gov/MLNMattersArticles/downloads/MM6792.pdf** on the CMS website.)

Medicare contractors and durable medical equipment (DME) suppliers requested clarification for particular situations that are listed below, and CR 6990 (from which this article is taken) provides that clarification.

This clarification in date of service (DOS) applies to the following oxygen concentrators and oxygen transfilling equipment, HealthCare Common Procedure Coding System (HCPCS) codes:

- E1390 - Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate;
- E1391 - Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each;
- E1392 - Portable oxygen concentrator, rental;
- 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; and
- K0738 - Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing.

It does **not** apply to beneficiary-owned oxygen equipment or to the following liquid and gaseous oxygen equipment HCPCS codes:

- E0424 - Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing;
- E0431 - Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing;
- E0434 - Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing; or
- E0439 - Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing.

CR 6990 clarifies the following situations

1. **Date of Service for Multiple Visits**
   If multiple maintenance and servicing visits are needed, the DOS is the date of the first visit in the first month of the 6-month period during which an in home inspection of the equipment was performed.

2. **Date of Service for Delayed Visits**
   If an unavoidable delay (e.g., hospitalization of the beneficiary or beneficiary is out of the service area) causes the DOS to occur after the first month of a 6-month period, the DOS is the date of the first visit after the delay during which an in home inspection of the equipment was performed. The reason for the unavoidable delay must be documented by the supplier and maintained in the supplier's records. Payment for subsequent maintenance and servicing visits can occur no earlier than 6 months after the DOS of the delayed visit (i.e., the last visit date used to bill for the maintenance and servicing payment). As a result, a new sequence of 6 month periods for maintenance and service payment is established.

3. **Date of Service for Multiple Pieces of Oxygen Equipment**
   If both a stationary concentrator and portable transfilling equipment are serviced, and the 36-month rental payment cap for one piece of equipment was reached at a different time than the 36-month rental payment cap for the other piece of equipment, the DOS is the date of the visit which occurs during the 6-month period following the earliest of the dates that the 36-month rental caps was reached for either piece of equipment. Only one payment is allowable per beneficiary regardless of the number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment).

4. **Date of Service When a Maintenance and Servicing Warranty Applies**
   The applicable DOS must be at least 6 months after the 36-month rental cap for oxygen equipment or the end of the warranty period for maintenance and servicing, **whichever is later**.

Please remember that only one maintenance and servicing payment may be made for each 6-month period, regardless of the combination of stationary and portable oxygen equipment that the beneficiary uses. In addition, payment for maintenance and servicing cannot be made if the oxygen equipment is covered under a warranty; therefore, before you can bill for maintenance and servicing, you must confirm, and record, that the oxygen equipment is no longer covered under a warranty; and visit the beneficiary's home to inspect the equipment.

Finally, keep in mind that the *Medicare Claims Processing Manual*, Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)), Section 40 (Payment for Maintenance and Service for Non-ESRD Equipment), Subsection 40.1 (General) instructs your contractor to refer cases to the program integrity specialist if claims are submitted that do not appear to comply with program instructions.

For reference, a summary of service details from CR 6792 follows:

1. If a combination of stationary concentrator (E1390 or E1391) and transfilling equipment (K0738 or E0433) is furnished, the supplier should bill for the maintenance and servicing payment using the code for the concentrator (E1390 or E1391) and the MS modifier.

2. If a portable concentrator (billed using a combination of codes E1390 and E1392 during the 36-month rental period) is furnished, the supplier should bill for the maintenance and servicing payment using the code for the concentrator (E1390 or E1391) and the MS modifier.

3. Code E1392 should not be used when billing for maintenance and servicing.

4. If transfilling equipment (K0738 or E0433) is furnished and a separate concentrator is not furnished or is owned by the beneficiary, the supplier should bill for the maintenance and servicing payment using the code for the transfilling equipment (K0738 or E0433) and the MS modifier.

5. Also, only one maintenance and servicing payment may be made for each 6-month period, regardless of the number of visits. Although a visit is not required, separate payment is not allowable without an in home visit to inspect the equipment. Even if the supplier does not perform a maintenance and servicing visit and forgo payment, 42 CFR 414.226(f)(1) continues to require the supplier that furnished the oxygen equipment for the 36th continuous rental month to furnish the equipment in good working order for the remaining period of medical need or the end of the equipment's reasonable useful lifetime (5 years).

Additional Information
You can find the official instruction, CR 6990, issued to your RHHI, MAC, or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R717OTN.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.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Discarded Drugs and Biologicals Policy at Contractor Discretion (MM7095) (DRU)

MLN Matters® Number: MM7095
Related CR Release Date: August 20, 2010
Related CR Transmittal #: R758OTN
Related Change Request (CR) #: 7095
Effective Date: July 30, 2010
Implementation Date: September 21, 2010

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs) and/or durable medical equipment (DME) MACs) for drugs or biologicals administered to Medicare beneficiaries.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 7095 which is being issued in response to inquiries related to CR 6711 pertaining to the use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs and biologicals.

What You Need to Know
CR 7095 instructs that each Medicare contractor 1) has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and 2) will notify their respective providers of such requirements associated with the use of the JW modifier.

What You Need to Do
Your Medicare contractor will provide you with details concerning the use of the JW modifier for discarded drugs and biological. Be sure to follow those requirements.

Background
Previously, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6711 (see the MLN Matters® article related to CR 6711 at **http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf** on the CMS website)) which updated the *Medicare Claims Processing Manual* (Chapter 17, Section 40) and provided policy on the appropriate use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs or biologicals. After issuing CR 6711, CMS received several inquiries from various providers regarding how the JW modifier is to be used for their Medicare Part B drug claims.

CR 7095 is being issued in response to these inquiries, and it instructs that each Medicare contractor:

- Has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and

- Will notify their respective providers of such requirements associated with the use of the JW modifier.

Additional Information
The official instruction, CR 7095, issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R758OTN.pdf** on the CMS website.

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

Durable Medical Equipment National Competitive Bidding Implementation – 10G: Paying for Oxygen Equipment when Grandfathered (MM6934) (OXY)

MLN Matters® Number: MM6934
Related CR Release Date: June 10, 2010
Related CR Transmittal #: R718OTN
Related Change Request (CR) #: 6934
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected
This article is for grandfathered suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen equipment furnished to Medicare beneficiaries after the start of a DMEPOS Competitive Bidding Program.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6934 to alert suppliers that a **non-contract supplier who chose to be a grandfathered supplier for oxygen and oxygen equipment (i.e. portable or stationary) should also furnish additional oxygen equipment when medically necessary (i.e. portable or stationary) after the start of a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program to beneficiaries residing in a Competitive Bidding Area (CBA) who are already receiving oxygen equipment from the grandfathered supplier.**

Key Points of CR6934

- If a beneficiary resides in a CBA, Medicare will pay claims for portable or stationary oxygen equipment that is acquired on or after the start of the Round One Rebid, at the single payment amount, when submitted by a grandfathered supplier, if the same supplier furnished stationary or portable oxygen equipment (grandfathered item), respectively, prior to the start of the Round One Rebid DMEPOS Competitive Bidding Program.

- If a beneficiary resides in a CBA, **claims will be denied** for portable or stationary oxygen equipment that is acquired on or after the start date for the Round One Rebid, **when submitted by a non-contract supplier, if the supplier did not furnish the portable or stationary oxygen equipment prior to the start of the National Competitive Bid Round One Rebid** (the portable or stationary oxygen equipment is not a grandfathered item).

- For oxygen equipment (stationary or portable) claims with dates of service on or after the start of the Round One Rebid, for a beneficiary residing in a CBA, claims will be denied when submitted by a grandfathered supplier, if the same grandfathered supplier did not furnish oxygen equipment (portable or stationary) prior to the start of the Round One Rebid (the items are not grandfathered).

- **Be aware that** a grandfathered supplier of oxygen and oxygen equipment cannot elect to grandfather stationary oxygen equipment and not portable oxygen equipment or vice versa. In accordance with the Medicare law and regulations, the Medicare monthly payment amount for stationary oxygen equipment includes payment for stationary oxygen equipment, stationary oxygen contents, and portable oxygen contents. If the supplier is also furnishing portable oxygen equipment, an add-on payment is made for the portable oxygen equipment only. Since payment for portable oxygen contents is included in the monthly payment amount for stationary oxygen equipment , the supplier must be a grandfathered supplier for both stationary and portable oxygen equipment in order to be in compliance with the statutorily mandated payment structure for oxygen and oxygen equipment. The grandfathered supplier that is grandfathering oxygen & oxygen equipment (i.e. stationary

or portable) to a beneficiary residing in a CBA is required to furnish any additional oxygen equipment (i.e. portable or stationary) the beneficiary needs following the implementation of a competitive bidding program.

Note: "*Acquisition*" in the context of CMS business rules means that the beneficiary's oxygen Certificate of Medical Necessity (CMN) initial date is prior to the start date for the DMEPOS Competitive Bidding Program Round One Rebid.

Background

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

Additional Information

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

The official instruction associated with this CR6934, issued to your Medicare MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R718OTN.pdf** on the CMS website.

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

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

MLN Matters® Number: MM7064
Related CR Release Date: August 20, 2010
Related CR Transmittal #: R2033CP
Related Change Request (CR) #: 7064
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a one time election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to

exercise this option must do so on or before November 1, 2010. See the Background and Additional Information Sections of this article for further details regarding the ESRD PPS.

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

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

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

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

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

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

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

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

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

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

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

Treatments furnished to pediatric patients:
- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

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

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

The ESRD PPS 4-year Transition Period Blended Rate Determination

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

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

The **ESRD PPS base rate is $229.63**, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where
- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

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

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:
- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

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

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

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

Three New Adjustments Applicable to the Adult Rate
1. **Comorbid Adjustments:** The new ESRD PPS provides for **3 categories of chronic comorbid conditions** and **3 categories for acute comorbid conditions**. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be

paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. **The 3 chronic comorbid categories** eligible for a payment adjustment are:

- Hereditary hemolytic and sickle cell anemia;
- Monoclonal gammopathy (in the absence of multiple myeloma); and
- Myelodysplastic syndrome.

The **3 acute comorbid categories** eligible for a payment adjustment are:

- Bacterial Pneumonia;
- Gastrointestinal Bleeding; and
- Pericarditis.

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

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

Change in Processing Home Dialysis Claims

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

Therefore, all home dialysis claims:

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

Note: *CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.*

Consolidated Billing

CR 7064 provides an ESRD consolidated billing requirement for limited Part B services included in the ESRD facility bundled payment. Certain laboratory services and limited drugs and supplies will be subject to Part B consolidated billing and will no longer be separately payable when provided for ESRD beneficiaries by providers other than the renal dialysis facility. Should these lab services, and limited drugs be provided to a beneficiary, but are not related to the treatment for ESRD, the claim lines must be submitted by the laboratory supplier or other provider with the new AY modifier to allow for separate payment outside of ESRD PPS. ESRD facilities billing for any labs or drugs will be considered part of the bundled PPS payment unless billed with the modifier AY. In addition, as noted above, Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7964) by DME suppliers when submitted for services not related to the beneficiary's ESRD dialysis treatment and such services are billed with the AY modifier.

Other Billing Reminders

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

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

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

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

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

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

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

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

Additional Information
The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2033CP.pdf** on the CMS website. Attached to CR 7064, you may find the following documents to be helpful:

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

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

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

MLN Matters® Number: MM6945
Related CR Release Date: July 1, 2010

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

Related CR Transmittal #: R1993CP

Note: *This article was revised on July 1, 2010, to reflect changes made by the release of an updated Change Request (CR) 6954. Language on page 2 in bold was corrected to state that claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 will be adjusted if brought to the contractor's attention. In addition, the Transmittal number, CR release date, and web address for the CR has been changed. All other material remains the same.*

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

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

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

Key Points of CR6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. **Claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 with dates of service on or after January 1, 2010 that have already been processed may be adjusted to reflect the newly established fees if brought to the attention of your Medicare contractor.**

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

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

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

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

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

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

The official instruction (CR6945) issued to your Medicare DME MAC may be found at **http://www.cms.gov/transmittals/downloads/R1993CP.pdf** on the CMS website.

New Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Specialty Code for Ocularists (MM6891) (SPE)

MLN Matters® Number: MM6891
Related CR Release Date: August 20, 2010
Related CR Transmittal #: R2030CP
Related Change Request (CR) #: 6891
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected
Suppliers and providers who bill Medicare Carriers, Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for ocular services to Medicare beneficiaries are affected by this change.

Provider Action Needed
This article is based on Change Request (CR) 6891 that instructs Ocularists to use the new DMEPOS specialty code B5 as a valid primary and/or secondary specialty code.

Background
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6891 to reflect the establishment of the new DMEPOS specialty code for Ocularists which is B5. Specialty codes are used by CMS for programmatic and claims processing purposes. They are used in expenditure analysis, and Medicare contractors use specialty code data to develop claims processing edits.

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

The official instruction, CR6891, issued to your Medicare A/B MAC, DME MAC or carrier regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2030CP.pdf** on the CMS website.

October 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7007) (DRU)

MLN Matters® Number: MM7007
Related CR Release Date: June 18, 2010
Related CR Transmittal #: R1990CP

Related Change Request (CR) #: 7007
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

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

Provider Action Needed
This article is based on Change Request (CR) 7007 and instructs Medicare contractors to download and implement the October 2010 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised, July 2010, April 2010, January 2010 and October 2009 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010. See the Background and Additional Information Sections of this article for further details regarding these changes.

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

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

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

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

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

The official instruction (CR7007) issued to your Medicare MAC, carrier, and/or FI may be found at **http://www.cms.gov/Transmittals/downloads/R1990CP.pdf** on the CMS website.

October Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM7070) (GEN)

MLN Matters® Number: MM7070
Related CR Release Date: July 23, 2010

Related CR Transmittal #: R2006CP

Related Change Request (CR) #: 7070
Effective Date: January 1, 2010 for codes in effect then, October 1, 2010 for other changes
Implementation Date: October 4, 2010

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed
This article is based on CR 7070, which provides the required quarterly update of the 2010 DMEPOS Fee Schedule. Be sure billing staffs are aware of the update.

Background
The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at **https://www.cms.gov/manuals/downloads/clm104c23.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Key Points of CR7070

- Per Transmittal 686 (Change Request 6743), the claims filing jurisdiction for HCPCS code L8509 (Tracheo-Esophageal Voice Prosthesis, Inserted by a Licensed Health Care Provider, Any Type) is changing from the DME MACs to the A/B MACs/Part B carriers, **effective October 1, 2010**. To reflect this change, the claims jurisdiction for code L8509 will change in the DMEPOS fee schedule file to local carrier as part of this update.

- As part of this update, the Alaska and Hawaii fee schedule amounts for HCPCS code E0973 (*Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each*) are being revised in order to correct errors made in the calculation of the fee schedule amounts. Medicare contractors **will adjust previously processed claims for code E0973 with dates of service on or after January 1, 2010, if they are resubmitted as adjustments.**

Additional Information
The official instruction, CR 7070, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2006CP.pdf** on the CMS website.

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

An earlier MLN Matters® article, MM6743 on the *Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prostheses Healthcare Common Procedure Coding System (HCPCS) Code* may be reviewed at **http://www.cms.gov/MLNMattersArticles/downloads/MM6743.pdf** on the CMS website.

Payment for Replacement of Oxygen Equipment in Bankruptcy Situations (MM6838) (OXY)

MLN Matters Number: MM6838
Related CR Release Date: April 30, 2010
Related CR Transmittal #:1961CP

Related Change Request (CR) #: 6838
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Provider Types Affected
Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (MACs) and DME MACs) for oxygen and oxygen equipment provided to Medicare beneficiaries are affected.

Provider Action Needed
This article is based on Change Request (CR) 6838 and informs suppliers of DMEPOS that Medicare contractors may make payment for replacement oxygen equipment in the event that a supplier files for Chapter 7 or 11 bankruptcy in a United States Bankruptcy Court. Please be sure that your billing staffs are aware of this change.

Background
CR 6838 adds Section 50.4 to Chapter 20 of the *Medicare Claims Processing Manual* to provide instructions, regarding payment for the replacement of oxygen equipment in the event that a supplier files for Chapter 7 or 11 bankruptcy under Title 11 of the United States Code and is unable to continue furnishing oxygen and oxygen equipment to patients.

In accordance with 42 CFR Sections 414.210(f) and 414.226(g), payment can be made for replacement of oxygen equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen or irreparably damaged, resulting in a new reasonable useful lifetime period and a new 36 month rental payment period.

Payment Documentation Requirements
Medicare contractors are to verify supporting documentation and consider oxygen equipment as lost in certain bankruptcy situations. Payment may then be provided for the replacement of oxygen equipment and a new reasonable useful lifetime period and a 36 month rental payment period may begin on the date that the new, replacement equipment is furnished.

Similar to other situations where oxygen equipment is lost, stolen, or irreparably damaged, the contractor must verify that following claims information is included and valid with the claim:

- The most recent test date and blood gas testing result,
- Oxygen Certificate of Medical Necessity (CMN),
- The Healthcare Common Procedure Coding System (HCPCS) code for the new oxygen equipment (Stationary oxygen equipment - E0424, E0439, E1390, E1391, E1405 or E1406 or Portable oxygen equipment - E0431, E0433, E0434, E1392, or K0738),
- The HCPCS modifier RA (*Replacement of a DME Item*), and
- A narrative describing why the equipment was replaced. **Note:** Proof-of-delivery documentation from the previous supplier is not required.

In addition, the contractor must verify the following information is included and valid to support the supplier declared Chapter 7 or 11 bankruptcy under Title 11 of the United States Code bankruptcy and is unable to continue furnishing oxygen and oxygen equipment to patients:

a. For a Chapter 7 bankruptcy, supporting documentation must include court records documenting that the previous supplier filed a petition for a Chapter 7 bankruptcy in a United States Bankruptcy Court; and
b. For a Chapter 11 bankruptcy, supporting documentation must include court records documenting that the previous supplier filed a petition for a Chapter 11 bankruptcy in a United States Bankruptcy Court, and documents filed in the bankruptcy case confirming that the equipment was sold or is scheduled to be sold as evidenced by one of the following:
    - The court order authorizing and/or approving the sale; or
    - Supporting documentation that the sale is scheduled to occur or has occurred (e.g., a bill of sale, or an asset purchase agreement signed by the seller and the buyer); or
    - A court order authorizing abandonment of the equipment.

Messages for Denied Claims
Contractors will deny claims for replacement oxygen equipment due to bankruptcy if verification of the above supporting documentation is unsuccessful.

When denying claims for replacement oxygen equipment due to insufficient supporting documentation, the following reason and remark codes and messages will be used:

- Group Code CO (Contractual Obligation),
- A1 - Claim/Service Denied,
- N225 - Incomplete/invalid documentation/orders/notes/summary/report/chart, and
- MSN 9.2 - This item or service was denied because information required to make payment was missing. (Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.).

Note: *No payment will be made for replacement equipment when the original supplier divests business and equipment outside of the court bankruptcy process.*

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

Fee Schedule Updates (GEN)

The 2010 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. This quarter the following notices have been posted:

- 3rd Quarter 2010 Jurisdiction A DME MAC Fee Schedule
- 3rd Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 3rd 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.

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.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (MM7089) (GEN)

MLN Matters® Number: MM7089
Related CR Release Date: August 6, 2010
Related CR Transmittal #: R2019CP

Related Change Request (CR) #: 7089
Effective Date: October 1, 2010
Implementation Date: October 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 7089, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2010 for Medicare. These are the changes that have been added since CR 6901. Be sure billing staff are aware of these changes.

Background
The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year - in early March, July, and November although the Committee meets every month.

The CARC list is maintained by the Claim Adjustment Status Code Maintenance Committee, and used by all payers. This committee meets 3 times a year, and this code list also gets updated 3 times a year - in 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 7089.

Additional Information
To see the official instruction (CR7089) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to **http://www.cms.gov/Transmittals/downloads/R2019CP.pdf** on the CMS website.

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

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
235	Sales Tax.	6/6/2010

Modified Codes - CARC
None

Deactivated Codes - CARC
None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.	NO
N534	This is an individual policy, the employer does not participate in plan sponsorship.	NO

Code	Current Narrative	Medicare Initiated
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.	YES
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.	NO
N537	We have examined claims history and no records of the services have been found.	NO
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	NO
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.	NO

Modified Codes - RARC

Code	Modified Narrative	Medicare Initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at **www.cms.gov**.	YES
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	YES
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at **www.cms.gov/mcd/search.asp**. If you do not have web access, you may contact the contractor to request a copy of the NCD.	YES
N528	Patient is entitled to benefits for Institutional Services only.	NO
N529	Patient is entitled to benefits for Professional Services only.	NO
N530	Not Qualified for Recovery based on enrollment information.	NO

Deactivated Codes - RARC

Code	Current Narrative	Note
M118	Letter to follow containing further information.	Consider using N202
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Consider using N130

Claim Status Category and Claim Status Code Update (MM7052) (GEN)

MLN Matters® Number: MM7052
Related CR Release Date: July 16, 2010
Related CR Transmittal #: R2002CP

Related Change Request (CR) #: 7052
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

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

Provider Action Needed
This article, based on CR7052, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement were updated during the June 2010 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on or about July 1, 2010. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on October 4, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background
The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

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

The official instruction, (CR7052), issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2002CP.pdf** on the CMS website.

Clinical Review Judgment (MM6954) (GEN)

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

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

Note: *This article was revised on June 16, 2010, to include an additional reference to Chapter 3 of the Medicare Program Integrity Manual on page 2. All other information remains the same.*

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

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

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

Background
Medicare claim review contractors (Carriers, Fiscal Intermediaries (called affiliated contractors, or ACs), Medicare Administrative Contractor (MACs), the Comprehensive Error Rate Testing (CERT) contractor, and Recovery Audit Contractors (RACs)), along with Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC) are tasked with measuring, detecting and correcting improper payments in the Fee for Service (FFS) Medicare Program.

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

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

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

Additional Information
You can find more information about clinical review judgment by going to CR 6954, located at **http://www.cms.gov/Transmittals/downloads/R338PI.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section14 (Clinical Review Judgment) as an attachment to that CR. The original Chapter 3, which contains more information on CMS' medical review processes, is available at **http://www.cms.gov/manuals/downloads/pim83c03.pdf** on the CMS website.

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

Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted or Terminated (MM6625) (GEN)

MLN Matters® Number: MM6625
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R2014CP
Related Change Request (CR) #: 6625
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

What You Need to Know
CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen Group Health Plan (GHP) Medicare Secondary Payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare's database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the Background section, below, for more details.

Background
MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

1. Reopen certain MSP claims when certain MSP records are deleted, or
2. Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare Secondary Payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional Information
You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R2014CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

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

MLN Matters® Number: MM6918 Revised
Related CR Release Date: June 18, 2010
Related CR Transmittal #: R721OTN
Related Change Request (CR) #: 6918
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Note: *This article was revised on June 21, 2010, to reflect the revised CR 6918 that was issued on June 18, 2010. The article was changed to include a revised first bullet point in the "Key Points of CR 6918" section. Also, the CR release date, transmittal number, and the Web address for accessing CR 6918 were revised. All other information remains the same.*

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

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6918 to alert providers that under certain circumstances Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) payment will be allowed for grandfathered items for beneficiaries who received services from a DMEPOS supplier while under a Medicare Advantage plan. Those items should be

furnished by a non-contract Medicare Advantage (MA) supplier under the DMEPOS Competitive Bidding Program for a beneficiary who resides in a competitive bidding area (CBA) and elects to leave their MA plan or loses his/her coverage under this plan. Such beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program.

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

Key Points of CR6918

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

Background

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

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

Additional Information

If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction associated with this CR6918, issued to your Medicare DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R721OTN.pdf** on the CMS website.

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

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

MLN Matters® Number: MM6911 Revised
Related CR Release Date: June 14, 2010
Related CR Transmittal #: R1988CP

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

Note: *This article was revised on June 14, 2010, to reflect the revised CR 6911 that was issued on that date. In this article, the CR release date and transmittal number (see above) were revised. Also, the Web address for accessing CR 6911 was revised. All other information remains the same.*

Provider Types Affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors

(A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

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

What You Need to Know
Consolidated Billing Edit Modification
Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the *Medicare Claims Processing Manual*, chapter 10, section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.

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

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

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

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

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

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

NOTE: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particularly true regarding physician certification billing. Historically, Medicare has paid certification codes for

less than 40% of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Additional Information
If you have questions, please contact your Medicare RHHI/MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction (CR6911) issued to your Medicare RHHI/MAC is available at **http://www.cms.gov/Transmittals/downloads/R1988CP.pdf** on the CMS website.

Guidance on Implementing Section 3109 of the Patient Protection and Affordable Care Act (ACA) (MM7021) (GEN)

MLN Matters® Number: MM7021 Revised
Related CR Release Date: June 25, 2010
Related CR Transmittal #:R346PI

Related Change Request (CR) #: 7021
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: This article was re-issued on August 27, 2010, to include the above news flash as a reminder of the upcoming DMEPOS Competitive Bidding Program and to add a Web link to the Provider/Supplier Accreditation page on the CMS website. That link is in the "Additional Information" section of the article. All other information is the same.

Provider Types Affected
This article is for Durable Medical Equipment Prosthetics and Orthotics Suppliers (DMEPOS).

Provider Action Needed
This article is based on Change Request (CR) 7021, which revises the Medicare *Program Integrity Manual* (Chapter 15 (Medicare Provider/Supplier Enrollment)) to include Section 38.6.1 (Compliance Standards for Pharmacy Accreditation). This article explains the revised requirements for pharmacies as a result of Section 3109 (a) of the Patient Protection and Affordable Care Act (ACA). That section states that certain pharmacies are not required to have submitted evidence of accreditation to the Secretary of Health and Human services prior to January 1, 2011. See the Background section of this article for complete details.

Background
The Medicare Modernization Act of 2003 (MMA; Section 302) added a new paragraph 1834(a)(20) to the Social Security Act (see **http://www.ssa.gov/OP_Home/ssact/title18/1834.htm** on the Internet) that required the Centers for Medicare & Medicaid Services (CMS) to establish and implement quality standards for suppliers of DMEPOS. All DMEPOS suppliers that furnish such items or services identified in Section 1834(a)(20)(D) of the Social Security Act (as CMS determines appropriate) must comply with the quality standards in order to receive Medicare Part B payments and to retain Medicare billing privileges.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA); Section 154(b); (see **http://thomas.loc.gov/cgi-bin/bdquery/z?d110:SN03101**: on the Internet) added a new subparagraph (F) to Section 1834(a)(20) of the Social Security Act. In implementing quality standards under this paragraph, CMS required suppliers furnishing items and service on or after October 1, 2009, to have submitted evidence of accreditation by an accreditation organization designated by CMS.

The ACA, Section 3109 (a)) amends MIPPAA (subparagraph (F)(i) of Section 154(b)(1)(A)) by not requiring a pharmacy to submit to CMS such evidence of accreditation prior to January 1, 2011.

Also, with respect to items and services furnished on or after January 1, 2011, the ACA (section 3109 (a)) provides that the quality standards and accreditation requirements set forth in MIPPA (Section 1834(a)(20)(F)) will not apply to such pharmacies if the pharmacy meets each of the following:

1. The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the CMS;
2. The pharmacy has been enrolled under Section 1866(j) of the Social Security Act as a supplier of DMEPOS, and has been issued a provider number for at least 5 years;

3. No final adverse action (as defined in Section 424.579a) of title 42, Code of Federal Regulations) has been imposed in the past 5 years;
4. The pharmacy submits an attestation that the pharmacy meets the first three criteria listed above; and
5. The pharmacy agrees to submit materials as requested during the course of an audit conducted on a random sample of pharmacies selected annually.

The National Supplier Clearinghouse (NSC) will not require that a pharmacy be accredited as a condition of enrollment before January 1, 2011. The NSC-Medicare Administrative Contractor (MAC) will determine which enrolled suppliers are pharmacies that are not accredited and who will be enrolled for 5 calendar years prior to January 1 of the next calendar year. The NSC-MAC will then send a notice of revocation by January 10, 2011, to all enrolled pharmacies who are not accredited **or who are not exempt from the accreditation requirements.** The NSC-MAC will prepare a letter which enables all individually enrolled practice locations of pharmacies who have been enrolled for five calendar years prior to January 1, 2011, to attest that they are exempt from the requirement to be accredited because their total DMEPOS billings subject to accreditation are less than 5 percent of their total pharmacy sales, as determined based upon the total pharmacy sales of the pharmacy for the previous 3 calendar or fiscal years. The letter will cite that the attestation requires the signature of the authorized or delegated official of the entity. The authorized and delegated officials are defined in Section 15 of the Medicare Enrollment Application (CMS -855S) and as described in the internet enrollment application version of the Provider Enrollment, Chain and Ownership System (PECOS). The letters should be mailed between October 1, 2010, and October 31, 2010.

For pharmacies with more than one practice location, the letters will cite the need for each individually enrolled practice location to attest that they are exempt from the accreditation requirements. New locations of enrolled chain pharmacies will not be considered to have been enrolled for five calendar years. Pharmacies that have had a change of ownership in the prior five years, which resulted in a change in their legal business entity, including a change in their tax identification number (TIN), will not qualify for an attestation accreditation exemption.

The NSC-MAC will review the attestations received from pharmacies. Pharmacies that properly signed the attestation letter will be given an accreditation status of exempt. The NSC will make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their attestations. The NSC-MAC will send a notice of revocation by January 10, 2011, to all enrolled pharmacies who were sent an attestation letter and have not properly completed it as of the date of the notice of revocation. The notice of revocation will cite that the revocation is for a lack of required accreditation.

Between April 1, 2011, and April 30, 2011, the NSC-MAC will compile a sample listing of at least 10 percent of the pharmacies that have submitted an NSC accepted attestation exempting them from accreditation. The NSC-MAC will develop a letter to be sent to pharmacies that will be audited to determine if their accreditation exemption attestations are correct. The letter will request submission of evidence substantiating the validity of the pharmacy supplier's attestation. At a minimum, requested materials for this evidence will include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods.

The NSC-MAC will determine the acceptability of the replies received in response to the audit verification random sample mailing. The NSC will use DMEPOS billing data for only products and services requiring accreditation to assist in the determination. The NSC will make attempts to assist and follow-up with pharmacy suppliers that have not submitted or properly completed their audit verifications.
By June 30, 2011, the NSC-MAC will send a notice of revocation to all enrolled pharmacies that were sent an audit verification letter who did not submit satisfactory evidence that they were in compliance with the requirements to obtain an accreditation exemption. The notice of revocation will cite that the revocation is for a lack of required accreditation.

Additional Information
The official instruction, CR 7021, issued to your DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R346PI.pdf** on the CMS website.

More information regarding accreditation can be found at the provider/supplier accreditation page located at **http://www.cms.gov/MedicareProviderSupEnroll/07_DMEPOSAccreditation.asp** on the CMS website.

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

Guidelines to Allow Contractors to Develop and Utilize Procedures for Accepting and Processing Appeals via Facsimile and/or via a Secure Internet Portal/Application (MM6958) (GEN)

MLN Matters® Number: MM6958
Related CR Release Date: June 11, 2010
Related CR Transmittal #: R1986CP

Related Change Request (CR) #: 6958
Effective Date: October 1, 2010
Implementation Date: October 1, 2010

Provider Types Affected
This article is for physicians, providers, and suppliers submitting Medicare fee-for-service (FFS) claim appeal requests to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 6958 which updates the current instructions in the *Medicare Claims Processing Manual*, Chapter 29, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application.

What You Need to Know
CR 6958 provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via facsimile and/or via a secure Internet portal/application. At this time, Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must seek approval from the Centers for Medicare & Medicaid Services (CMS) prior to implementation of that portal/application.

What You Need to Do
Note that, even if your contractor allows submission of appeal requests via facsimile and/or via a secure Internet portal/application, the decision to use those venues is yours. Your contractor may not require you to use those venues. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Several Medicare contractors have requested authority from the CMS to utilize a secure Internet portal/application to receive and process Medicare FFS claim appeal requests. In addition, several Medicare contractors have begun to accept claim appeal requests received in writing via facsimile.

CR 6958 provides guidance regarding appeal requests received in writing via facsimile or via a secure Internet portal/application, and it provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via these mechanisms.

The purpose of CR 6958 is to update the current instructions in the *Medicare Claims Processing Manual*, Chapter 29 (Appeals of Claims Decisions), to allow Medicare contractors to accept appeal requests via facsimile and/or via a secure Internet portal/application.

CMS does not require its contractors to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application is at the discretion of the appellant. Contractors will continue to accept appeal requests in hard copy via mail. Key portions of CR 6958 for providers are as follows:

What Constitutes a Request for Redetermination
Written Requests for Redetermination Submitted by a State, Provider, Physician or Other Supplier
States, providers, physicians, or other suppliers with appeal rights must submit written requests via mail, facsimile (if the contractor chooses to receive requests via facsimile), or, where available, secure Internet portal/application indicating what they are appealing and why. The acceptable written ways of doing this are via:

- **A completed Form CMS-20027 (constitutes a request for redetermination).** The contractor supplies these forms upon request by an appellant. "Completed" means that all applicable spaces are filled out and all necessary attachments are included with the request.
- A written request not on Form CMS-20027.
  At a minimum, the request shall contain the following information:
  - Beneficiary name;
  - Medicare health insurance claim (HIC) number;
  - The specific service(s) and/or item(s) for which the redetermination is being requested;
  - The specific date(s) of the service; and
  - The name and signature of the party or the representative of the party.

  Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either: (1) explicitly asks the contractor to take further action, or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination.

- **A secure Internet portal/application.** If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall include the required elements for a valid appeal request as outlined under Chapter 29, Section 310.1.B.2.b which is attached to CR 6958.

Note: *Some redetermination requests may contain attachments. For example, if the Remittance Advice (RA) is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.*

Requirements for a Valid Signature on an Appeal Request:
For appeal purposes, the only acceptable method of documenting the appellant's signature on the appeal request is by written, digital, digitized, or electronic signature as discussed below:

- A **written signature** may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- An **electronic, digital, and/or digitized signature** is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application. The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, "electronically signed by" or "verified/approved by" etc.
- A **stamp signature or other indication that a "signature is on file"** on the CMS 20027 form or other documentation (such as a blank claim form) submitted to support the appeal request shall not be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

How Contractors will Handle Multiple Requests for Redetermination for the Same Item/Service:
If a contractor receives multiple timely requests for redetermination for the same item or service from either multiple parties or via multiple venues (i.e., hard copy mail, facsimile, or via a secure Internet portal/application) the contractor acts as follows:

- If a decision or dismissal notice has already been issued or the claim for the item/service at issue has been adjusted/paid in accordance with the redetermination decision and the contractor receives additional redetermination request(s) for the same items/services, the contractors will treat the additional request as an inquiry. Contractors **shall not** issue a dismissal notice.

Note: *In accordance with the Medicare Claims Processing Manual (Chapter 29, Section 310.6.3 which is attached to CR6958), if an appellant requests that the contractor vacates its dismissal action and the contractor determines that it cannot vacate the dismissal; it sends a letter notifying the appellant accordingly. The contractor shall not issue a second dismissal notice to the appellant since a dismissal should only be issued in response to an appeal request.*

- If a decision or dismissal notice has not been issued (i.e., the appeal is pending), and the claim for the items/services at issue has not been otherwise adjusted/paid following the redetermination decision, then upon receipt of additional redetermination request(s) for the same items/services, the contractor shall:

1. Combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with the requirements as outlined in 42 CFR 405.944(c). See **http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr405.944.pdf** on the Internet.
2. When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that multiple requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized) so that it is clear to the appellant that the decision or dismissal was issued timely in accordance with 42 CFR 405.944(c).

- If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting multiple requests for redetermination via multiple venues, the contractor shall take additional steps to educate the appellant regarding the appeals process.

Timely Processing Requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of the *Medicare Claims Processing Manual*, Chapter 29, Section 310.4(D)(4), which is attached to CR 6958). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties. Affirmations processed via a CMS approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application.
2. For partial reversals and full reversals, when all of the following actions have been completed:
   - The decision letter, if applicable, is mailed to the parties (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application), and
   - The actions to initiate the adjustment action in the claims processing system are taken.
3. For withdrawals and dismissals, the date that the dismissal notice is mailed (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application) to the parties.

The Redetermination Decision

The law requires contractors to conclude and mail and/or otherwise transmit, as noted below, the redetermination within 60 days of receipt of the appellant's request, as indicated in the *Medicare Claims Processing Manual*, Chapter 29, Section 310.4, which is attached to CR 6958. For unfavorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and appointed representative, if applicable).

Contractors shall provide the decision, as required below; in writing via hard copy mail (unless the contractor has submitted a request and received approval for use of secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically). Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism.

Requirements for Use of Secure Internet Portal/Application to Support Appeals Activities

Contractors who develop and utilize a secure Internet portal/application for appeals purposes will ensure, at a minimum:

- CMS approves the proposed portal/application and usage prior to development and implementation.
- Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request (the system must include verbiage instructing the appellant not to submit additional redetermination requests for the same item/service via a different venue).
- The secure Internet portal/application includes a formal registration process that validates the signature and requires, at a minimum, use of restricted user IDs and passwords.
- Templates for submission of electronic appeal requests must include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- Contractors utilizing an approved portal/application must provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.

- Contractors must also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.
- Contractors utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.
- Redetermination decision and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements. In addition, contractors shall provide hard copy decision and/or dismissal notices to parties to the appeal and who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).
- Contractors will also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.

Additional Information
The official instruction, CR 6958, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R1986CP.pdf** on the CMS website.

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

ICD-10 Implementation Information (SE1019) (GEN)

MLN Matters® Number: SE1019
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 issue impacts all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

What You Need to Know
This MLN Matters® special edition article provides information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The first ICD-10-related compliance date is less than 2 years away. On **January 1, 2012**, standards for electronic health transactions change from Version 4010/4010A1 to Version 5010. Unlike Version 4010, Version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

On **October 1, 2013**, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background
ICD-10 Implementation Compliance Date
On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
    - There will be **no** delays.
    - There will be **no** grace period for implementation.

Important, please be aware:

- ***ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.***
- ***ICD-10 codes will not be accepted for services prior to October 1, 2013.***

You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2013, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2013.

Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2013.

Note: *Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures - it will not be used for physician reporting. There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report CPT and HCPCS codes.*

What are the Differences Between the ICD-10-CM/ICD-10-PCS and ICD-9-CM Code Sets?

The differences between the ICD-10 code sets and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail. There are approximately 70,000 ICD-10-CM codes compared to approximately 14,000 ICD-9-CM diagnosis codes, and approximately 70,000 ICD-10-PCS codes compared to approximately 4,000 ICD-9-CM procedure codes.

In addition, ICD-10 codes are longer and use more alpha characters, which enable them to provide greater clinical detail and specificity in describing diagnoses and procedures. Also, terminology and disease classification have been updated to be consistent with current clinical practice.

Finally, system changes are also required to accommodate the ICD-10 codes.

What are Benefits of the ICD-10 Coding System?

The new, up-to-date classification system will provide much better data needed to:

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition
- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization
- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

ICD-10-CM Code Use and Structure

The ICD-10-CM (diagnoses) codes are to be used by all providers in all health care settings. Each ICD-10-CM code is 3 to 7 characters, the first being an alpha character (all letters except U are used), the second character is numeric, and characters 3-7 are either alpha or numeric (alpha characters are not case sensitive), with a decimal after the third character. Examples of ICD-10-CM codes follow:

- A78 - Q fever
- A69.21 - Meningitis due to Lyme disease
- O9A.311 - Physical abuse complicating pregnancy, first trimester

- S52.131A - Displaced fracture of neck of right radius, initial encounter for closed fracture

Additionally, the ICD-10-CM coding system has the following new features:

1. Laterality (left, right, bilateral)
   For example:
   - C50.511 - Malignant neoplasm of lower-outer quadrant of right female breast
   - H16.013 - Central corneal ulcer, bilateral
   - L89.022 - Pressure ulcer of left elbow, stage II

2. Combination codes for certain conditions and common associated symptoms and manifestations
   For example:
   - K57.21 - Diverticulitis of large intestine with perforation and abscess with bleeding
   - E11.341 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
   - I25.110 - Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

3. Combination codes for poisonings and their associated external cause
   For example:
   - T42.3x2S - Poisoning by barbiturates, intentional self-harm, sequela

4. Obstetric codes identify trimester instead of episode of care
   For example:
   - O26.02 - Excessive weight gain in pregnancy, second trimester

5. Character "x" is used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than 6 characters in length requires a 7th character
   For example:
   - T46.1x5A - Adverse effect of calcium-channel blockers, initial encounter
   - T15.02xD - Foreign body in cornea, left eye, subsequent encounter

6. Two types of Excludes notes
   Excludes 1 - Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).
   For example:
   - Q03 - Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

   Excludes 2 - Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).
   For example:
   - L27.2 - Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

7. Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)
   For example:
   - T45.526D - Underdosing of antithrombotic drugs, subsequent encounter
   - Z67.40 - Type O blood, Rh positive
   - Y90.6 - Blood alcohol level of 120-199 mg/100 ml

8. A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)
   For example:
   - E10.610 - Type 1 diabetes mellitus with diabetic neuropathic arthropathy
   - F10.182 - Alcohol abuse with alcohol-induced sleep disorder
   - T82.02xA - Displacement of heart valve prosthesis, initial encounter

9. Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders
   For example:
   - D78.01 - Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen

- D78.21 - Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

Finally, there are additional changes in ICD-10-CM, to include:

- Injuries are grouped by anatomical site rather than by type of injury
- Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM
- Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge
- New code definitions (e.g., definition of acute myocardial infarction is now 4 weeks rather than 8 weeks)
- The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

To learn more about the ICD-10-CM coding structure you may review "*Basic Introduction to ICD-10-CM*" audio or written transcripts from the March 23, 2010 provider outreach conference call. Go to **http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage** on the CMS website. Scroll to the bottom of the web page to the Downloads section and select the 2010 ICD-10 Conference Calls zip file and locate the March 23rd written or audio transcript.

ICD-10-PCS Code Use and Structure

The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures. ICD-10-PCS codes are not to be used on any type of physician claims for physician services provided to hospitalized patients. These codes differ from the ICD-9-CM procedure codes in that they have 7 characters that can be either alpha (non-case sensitive) or numeric. The numbers 0 - 9 are used (letters O and I are not used to avoid confusion with numbers 0 and 1), and they do not contain decimals.

For example:

- 0FB03ZX - Excision of liver, percutaneous approach, diagnostic
- 0DQ10ZZ - Repair, upper esophagus, open approach

Help with Converting Codes

The General Equivalence Mappings (GEMs) are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM/PCS and vice versa. Mapping from ICD-10-CM/PCS codes back to ICD-9-CM codes is referred to as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM/PCS codes is referred to as forward mapping. The GEMs are a comprehensive translation dictionary that can be used to accurately and effectively translate any ICD-9-CM-based data, including data for:

- Tracking quality
- Recording morbidity/mortality
- Calculating reimbursement
- Converting any ICD-9-CM-based application to ICD-10-CM/PCS

The GEMs can be used by anyone who wants to convert coded data, including:

- All payers
- All providers
- Medical researchers
- Informatics professionals
- Coding professionals - to convert large data sets
- Software vendors - to use within their own products;
- Organizations - to make mappings that suit their internal purposes or that are based on their own historical data
- Others who use coded data

The GEMs are not a substitute for learning how to use the ICD-10 codes. More information about GEMs and their use can be found on the CMS website at **http://www.cms.gov/ICD10** (select from the left side of the web page ICD-10-CM or ICD-10-PCS to find the most recent GEMs).

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings". Go to **http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp**, scroll to the bottom of the page, under Downloads select - 2009 ICD-10 Conference Calls to locate the audio and written transcripts.

What to do Now in Preparation for ICD-10 Implementation?

- Learn about the structure, organization, and unique features of ICD-10-CM - all provider types
- Learn about the structure, organization, and unique features of ICD-10-PCS - inpatient hospital claims
- Learn about system impact and 5010
- Use assessment tools to identify areas of strength/weakness in medical terminology and medical record documentation
- Review and refresh knowledge of medical terminology as needed based on the assessment results
- Provide additional training to refresh or expand knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology)
- Plan to provide intensive coder training approximately 6 -9 months prior to implementation
- Allocating 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient ICD-9-CM coders may not need that much

Additional Information

To find additional information about ICD-10, visit **http://www.cms.gov/ICD10** on the CMS website. In addition, CMS makes the following resources available to assist in your transition to ICD-10:

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

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

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

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

- **Workgroup for Electronic Data Interchange (WEDI) http://www.wedi.org**; and
- **Health Information and Management Systems Society (HIMSS) http://www.himss.org/icd10** on the Internet.

Medical Record Retention and Media Formats for Medical Records (SE1022) (GEN)

MLN Matters® Number: SE1022
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 is an informational article for physicians, non-physician practitioners, suppliers, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
This Special Edition is informational in nature. There are no additions or changes to current policies and procedures.

What You Need to Know
This article provides guidance for physicians, suppliers, and providers on record retention timeframes.

What You Need to Do
Review the information in this article and ensure that you are in compliance. Be sure to inform your staff.

Retention Periods
State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for **six years from the date of its creation or the date when it last was in effect, whichever is later.** HIPAA requirements preempt State laws if they require shorter periods. **Your State may require a longer retention period.** The HIPAA requirements are available at 45 CFR 164.316(b)(2) (**http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl**) on the Internet.

While the HIPAA Privacy Rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. The Privacy Rule is available at 45 CFR 164.530(c) (**http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl**) on the Internet.

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report. This requirement is available at 42 CFR 482.24[b][1] (**http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr482_05.html**) on the Internet.

CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available at 42 CFR 422.504 [d][2][iii] (**http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr;sid=ab240bf0e5f6388a75cbe07cc5cf1d21;rgn=div5;view=text;node=42%3A3.0.1.1.9;idno=42;cc=ecfr**) on the Internet.

Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient. Remember that medical records must be accurately written, promptly completed, accessible, properly filed and retained. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.

The Medicare program does not have requirements for the media formats for medical records. However, the medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Providers may want to obtain legal advice concerning record retention after these time periods and medical document format.

Additional Information
CMS is currently engaged in a multi-year project to offer incentives to eligible providers that meaningfully use certified electronic health records (EHRs). In close coordination with this incentive program, the Office of the National Coordinator for Health IT (ONC) has developed the initial set of standards and certification requirements for EHRs in order to promote health information exchange and interoperability. You may be eligible to receive incentive payments to assist in implementing certified EHR technology systems.

Use of "certified EHR technology" is a core requirement for physicians and other providers who seek to qualify to receive incentive payments under the Medicare and Medicaid Electronic Health Record Incentive Programs provisions authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Additional information about this initiative may be found at **http://www.cms.gov/EHRIncentivePrograms/** on the CMS website.

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

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (MM7006) (GEN)

MLN Matters Number: MM7006 Revised
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Related CR Transmittal #: R2017CP
Related Change Request (CR) #: 7006
Effective Date: October 1, 2010
Implementation Date: October 4, 2010

Note: *This article was revised on August 4, 2010, to reflect the revised CR 7006, which was revised on August 4. In this article, the CR release date and Transmittal number (see above) were changed and the Web address for accessing CR 7006 was also changed. All other information is the same.*

Provider Types Affected
Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed
This article is based on Change Request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at **http://www.cms.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage**, or at the National Center for Health Statistics (NCHS) website at **http://www.cdc.gov/nchs/icd9.htm** in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

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

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

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

Additional Information
For complete details regarding this CR, please see the official instruction (CR7006) issued to your Medicare contractor, which may be found at **http://www.cms.gov/Transmittals/downloads/R2017CP.pdf** on the CMS website.

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

Medicare Policy Regarding Pressure Reducing Support Surfaces (SE1014) (MOB)

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Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised and re-issued in its entirety on August 17, 2010.*

Provider Types Affected
Suppliers and health care providers, such as home health agencies, who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for pressure reducing support surfaces for Medicare beneficiaries, are affected.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is issuing Special Edition (SE) 1014 to clarify existing support surface medical policies and coverage requirements. This article does not present new policy, but only reinforces existing policy. Be certain that your billing staffs are aware of these policies as outlined in the *Background* section of this article.

Background
In August of 2009, the Department of Health and Human Services (HHS), Office of Inspector General (OIG) issued a report entitled "Inappropriate Payments for Pressure Reducing Support Surfaces" (report numbered OEI-02-07-00420), regarding the inappropriate billing for Pressure Reducing Support Surfaces by Durable Medical Equipment Prosthetics Orthotics Supplies (DMEPOS) suppliers. The purpose was to determine the extent of inappropriate Medicare payments for pressure reducing support surfaces and to assess supplier compliance with DME MAC local coverage determinations (LCDs).

Pressure reducing support surfaces are a type of durable medical equipment (DME) used for the care of pressure sores, also known as pressure ulcers. Pressure ulcers are lesions caused by unrelieved pressure resulting in damage of underlying tissue. Support surfaces are coded under one of 16 different Healthcare Common Procedure Coding System (HCPCS) codes. A major distinction between support surfaces is that some are powered by electricity and others are not. They may be categorized into the following three groups:

- **Group 1** support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include mattresses, pressure pads and mattress overlays (foam, air, water, or gel).

- **Group 2** support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include powered air flotation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses.

- **Group 3** support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads.

Although LCDs are published by the four DME MAC contractors, inappropriate payments are still being made, and other problems continue to adversely affect Medicare reimbursement for this equipment. Therefore, CMS is taking additional steps listed here to reduce the extent of inappropriate support surface payments.

Required Documentation in Patient's Medical Record

- For any DMEPOS item to be covered by Medicare, the patient's **medical record must contain sufficient documentation** of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

- Suppliers should note that neither physicians' orders, nor supplier-prepared statements, nor physician attestations by themselves provide sufficient documentation of medical necessity, even though they may be signed by the treating physician or supplier. **There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN** (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable). (See *Medicare's Program Integrity Manual* (PIM), Chapter 3

(**http://www.cms.gov/manuals/downloads/pim83c03.pdf**), Section 3.4.1.1, for additional instructions, regarding review of documentation during pre- and post-payment)

- The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency (HHA) records and records from other health care professionals.

- The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MACs, DME Program Safeguard Contractors (PSCs), or Zone Program Integrity Contractors (ZPICs). However, the DME MACs, DME PSCs, or ZPICs may request this information in selected cases.

Required Supplier's Documentation

- Before submitting a support surface claim to the DME MAC the supplier must have on file a dispensing order, the detailed written order, information from the treating physician concerning the patient's diagnosis, and any information required for the use of specific modifiers or attestation statements as defined in certain DME MAC policies. The supplier should also obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item have been met. **If the information in the patient's medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.**

- Documentation must be maintained in the supplier's files for seven (7) years.

- Suppliers are required to maintain proof of delivery documentation in their files. The three proof of delivery requirements are:
  - Supplier delivering directly to the beneficiary or authorized representative;
  - Supplier utilizing a delivery/shipping service to deliver items; and
  - Delivery of items to a nursing facility on behalf of the beneficiary.

- Proof of delivery documentation must be available to the DME MAC, DME PSC, and ZPIC on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for imposition of civil monetary penalties (CMPs) or administrative sanctions.

Medicare Coverage of Support Surfaces

For all three support surface groups, patients should have a care plan established by their physician or home care nurse, which is documented in their medical records. This plan generally should include, among other things, education of the patient and regular assessment by a healthcare practitioner. Coverage for all three groups continues until the patient's pressure ulcer is healed.
In addition to the above common requirements, coverage for specific groups of support surfaces varies as follows:

- **GROUP 1** - A group 1 support surface is covered if the patient is completely immobile. Otherwise, he or she must be partially immobile, or have any stage pressure ulcer and demonstrate one of the following conditions: impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory status. A physician order must be obtained prior to delivery of the equipment and should be kept on file by the supplier.

- **GROUP 2** - A group 2 support surface is covered if the patient has a stage II pressure sore located on the trunk or pelvis, has been on a comprehensive pressure sore treatment program (which has included the use of an appropriate group 1 support surface for at least one month), and has sores which have worsened or remained the same over the past month. A group 2 support surface is also covered if the patient has large or multiple stage III or IV pressure sores on the trunk or pelvis, or if he or she has had a recent mycutaneous flap or skin graft for a pressure sore on the trunk or pelvis and has been on a group 2 or 3 support surface.

- **GROUP 3** - A group 3 support surface is covered if the patient has a stage III or stage IV pressure ulcer, is bedridden or chair-bound, would be institutionalized without the use of the group 3 support surface, the patient is under the close supervision of the patient's treating physician, at least one (1) month of conservative treatment has been administered (including the use of a group 2 support surface), a caregiver is available and willing to assist with patient care and all other alternative equipment has been considered and ruled out.

Additional Information
For more information regarding Documentation, refer to the PIM, Chapter 5 (**http://www.cms.gov/manuals/downloads/pim83c05.pdf**) on the CMS website. In addition, the DME MAC LCDs - Pressure Reducing Support Surface - Group 1, Pressure Reducing Support Surface - Group 2, Pressure Reducing Support Surface - Group 3 may be found on the CMS Medicare Coverage Database at **http://www.cms.gov/mcd** (search "support surfaces").

Providers may also want to review the Office of Inspector General (OIG) report, Inappropriate Payments for Pressure Reducing Support Surfaces OEI-02-07-00420. This report may be viewed at **http://www.oig.hhs.gov/oei/reports/oei-02-07-00420.pdf**

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

Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC) or from one Durable Medical Equipment (DME) MAC to another DME MAC (SE1017) (GEN)

MLN Matters® Number: SE1017
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was initially issued as SE0837 in 2008. It is being re-issued as SE1017 in order to update the content to reflect current experiences with transitions to a MAC.*

Provider Types Affected
All fee-for-service physicians, providers, and suppliers who submit claims to Fiscal Intermediaries (FIs), Carriers, Regional Home Health Intermediaries (RHHIs), or DME MACs for services provided to Medicare beneficiaries. **Providers already billing Medicare Administrative Contractors (MACs) have already transitioned and need not review this article. However, suppliers billing DME MACs may find the article of value as the Centers for Medicare & Medicaid Services (CMS) recompetes the DME MAC contracts, which could cause a transition from an incumbent DME MAC to a new DME MAC.**

Impact on Providers
This article is intended to assist all providers that will be affected by Medicare Administrative Contractor (MAC) implementations (or DME MAC transitions due to recompeting the DME MAC Contracts). CMS is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC (or your DME MAC to another DME MAC). Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business. Please note that other Medicare contractors servicing your region will be unaffected by this change, such as the Qualified Independent Contractor (QIC for reconsiderations), Recovery Audit Contractor (RAC), the Program Safeguard Contractor (PSC), and the Zone Program Integrity Contractor (ZPIC).

NOTE to DME suppliers: *The remainder of this article focuses on transitions from carriers or FIs to MACs, but suppliers note the information may also pertain to your business if there is a transition from your DME MAC to another DME MAC as those contracts are recompeted.*

Background
Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B Fee-For-Service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new MAC authority. Medicare Contracting Reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare FFS program.

When completed, there will be 15 new MACs processing Part A and Part B claims. Each MAC services a distinct set of contiguous states, also known as a "jurisdiction". Each MAC will handle different volumes of work based upon the geographic breakout of the 15

MACs. Because of this, the MACs will vary in geographic size and the amount of work they handle. Having 15 MACs should result in greater consistency in the interpretation of Medicare policies, which is a key goal of Medicare Contracting Reform.

MAC Implementation Milestones/Definitions
There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action relative to the milestones defined below:

Award - This is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

Cutover - This is the date on which the carrier or FI work ceases and MAC work begins. Cutover is often done in phases by State-level jurisdictions. Because of the amount of activity involved in a cutover, there may be interrupted services for a day or two.

Outgoing Contractor - A Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare Contracting Reform and whose work will transition to a MAC.

Incoming MAC - The entity that has won a contract under Medicare Contracting Reform and which will assume the workload that was performed by a carrier or FI.

Pre - Award
If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare Contracting Reform by visiting **http://www.cms.gov/medicarecontractingreform/** on the CMS website.

Post- Award
Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

Pay attention to the mail you receive from your outgoing Medicare contractor and your new MAC--you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic funds transfers, appeals, customer service, etc. Focus on necessary actions you must take and the critical due dates assigned, to avoid any disruptions in claims payment.

Sign up for your new MAC's listserv or if you aren't signed up for your current FI or carrier's listserv, please do so immediately. While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Subscribing to the MAC listserv distribution will ensure that you receive news and resource tools as they become available concerning the implementation.

Access and bookmark the MAC's website, particularly any part of the site devoted to information about the MAC transition/implementation) and visit it regularly. The MAC may have a new website that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.

Review the Frequently Asked Questions (FAQs) on the MAC's website.

Participate in the MAC's advisory groups and "Ask the Contractor" teleconferences. (Note that these advisory groups are usually limited in size.) Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC!

Review the MAC's Local Coverage Determinations (LCDs) as they may be different from the outgoing contractor's LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and website for information regarding potential changes to the LCDs.

Two-Three Months Prior to Cutover

- **Complete and return your Electronic Funds Transfer (EFT) agreements.** CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC **and, if you are not on EFT, this may be a good opportunity to consider enrollment in EFT.** (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank

account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and submit it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. If you fail to submit the CMS-588 form as required, the new MAC will place you in a "Do Not Forward" (DNF) status as required by Chapter 1, Section 80.5 of the *Medicare Claims Processing Manual*. Contact your MAC with any questions concerning the agreement.

The CMS-588 form can be found at **http://www.cms.gov/cmsforms/downloads/CMS588.pdf** on the CMS website.

You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's website. Your current contractor may also provide instructions on its website on accurately completing the form.

- Your new MAC may also request you to execute a new **Electronic Data Interchange (EDI) Trading Partner Agreement** as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available at **http://www.cms.gov/EducationMaterials/downloads/TradingPartner-8.pdf** on the CMS website.

- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their website for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these submitter IDs and passwords to you in hardcopy or electronically. **You don't need to do anything to get the new IDs**; however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.

- **Contact your claims processing vendor, billing department, and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"

- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.

- Be aware of the last date you can receive and download electronic remittance advices (ERAs) from your outgoing contractor.

- Be aware that some MACs may offer participation in an "early boarding" process for electronic claims submission and/or Electronic Remittance Advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password -watch for and document them for use after cutover to the MAC.

Cutover Weekend

Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend (weekend prior to cutover). Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.

Be aware that providers may also experience system "dark days" around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will have limited EDI processing and no access to Fiscal Intermediary Standard System (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

Be aware that some Interactive Voice Response (IVR) functionality may also be unavailable during a dark day.

Post-Cutover

- The first 1-2 weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.

- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll-free number for use.

- Be prepared that you may experience longer than normal wait times for Customer Service Representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.

- **Learn how to use the MAC's IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the Customer Service Representative (CSR) line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.

- Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's websites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.

- Be aware that there may be changes in faxing policies (e.g., for medical records).

- Be aware that there will be changes to PO Boxes and addresses for the submission of requests for Redeterminations (appeals), inquiries, and written reopening requests.

- Be aware that the MAC may edit claims differently from your outgoing contractor, so it is important to review your Remittance Advices (RAs) carefully to identify when this occurs.

- Be aware that you may experience changes in RA coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS Post-Cutover Monitoring

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

Additional Assistance

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A is a summary of what you need to do and information you will need;
- Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation; and
- Attachment C may be used to assist you in tracking major MAC milestones.

Additional Information

The following MLN Matters article provides additional information about the MAC implementation process:

- MM5979: *"Assignment of Providers to Medicare Administrative Contractors*" located at **http://www.cms.gov/MLNMattersArticles/downloads/mm5979.pdf** on the CMS website.

- MM6207: *"Initial Enrollment Assignment for Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs)*", located at **http://www.cms.gov/MLNMattersArticles/downloads/MM6207.pdf** on the CMS website.

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

SE1017 - Attachment A
TIMELINE AND CHECKLIST FOR PREPARING FOR MAC IMPLEMENTATION

Scheduled Award Date:
Actual Award Date:
MAC Contractor:
MAC Contractor Number:
MAC Mailing Address:

MAC Cutover Date:
MAC Scheduled Dark Days
MAC Website:
MAC Contact Center Number: 1-800-
MAC EDI Mailing Address:

90 DAYS BEFORE CUTOVER

1. Visit MAC website and bookmark for future use.
2. Join the MAC Listserv.
3. Monitor:
   - LCDs published by the new MAC; compare current LCDs that affect your practice's services.
4. Review:
   - Provider enrollment status for all providers, update as needed.
   - Pay-to address information for practice/providers, update as needed.
5. Contact:
   - Your Practice Management/Billing software vendor to determine if your system will be able to send & receive data to/from the new MAC.
   - Your claims clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.
   - Your billing department, vendor, or clearinghouse to be sure they are aware of the changes communicated from the incoming and outgoing contractors. To avoid delays in claims submission and processing and appeals requests submission, effective dates must be communicated to your appropriate provider staff and resources.

75 DAYS BEFORE CUTOVER

1. Check the MAC's website and/or Listserv for outreach programs, educational and informational events, FAQs, and conference calls.
2. Check your state's Medical Society or local provider organization website for MAC transition information, MAC Coordinators.

60 DAYS BEFORE CUTOVER

1. Submit CMS Form 588 - EFT form(s) to the new MAC, if needed.
2. Register for Electronic Remittance Advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample Remittance Advice (RA). RA codes are standard but use of codes may vary across contractors.
4. Submit test electronic claims as soon as new MAC indicates this is possible.

45 DAYS BEFORE CUTOVER

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

30 DAYS BEFORE CUTOVER

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI Submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims if you have not done so by now.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of the MAC website and e-mail from the MAC Listserv.

15 DAYS BEFORE CUTOVER

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational in the new environment.

3. Collect and record all MAC telephone and fax numbers for: General Inquiry Customer Service, Provider Enrollment, Provider Relations, EDI and ERA.
4. Become familiar with the MAC IVR query system by taking advantage of educational opportunities as most IVRs are not available until cutover because new outgoing claims/NPI information has not been loaded for accessibility.
5. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.

10 DAYS BEFORE CUTOVER

1. Address any existing open items.
2. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.

5-10 DAYS AFTER CUTOVER

1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.
3. Monitor and follow up on the MAC Open Item list.

30 DAYS AFTER CUTOVER

1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

SE1017 - Attachment B
SCHEDULE OF MAC CONTRACTOR TRAINING CLASSES

Scheduled Date	Title of Class	Attendee

SCHEDULE OF MAC CONFERENCES

Scheduled Date	Conference Subject	Attendee

SE1017 - Attachment C
Important MAC Implementation Dates

MAC Dark Days	
Cutoff Date for Claims Submission to the Outgoing Contractor	
Last Date Outgoing Contractor Will Make Payment	
Last Date Outgoing Contractor Will Have Telephone/Customer Service	
Last Date Outgoing Contractor Will Send File to Bank	
Last Date to Retrieve ERAs from Outgoing Contractor	
Date MAC Will Accept Electronic Claims	
Date MAC Will Accept Paper Claims	
Date MAC Bill/Claim Cycle Begins	
Date MAC Will Accept Written Appeals Requests (Redeterminations)	
First Anticipated MAC Payment Date	
Date MAC Begins Customer Service	

Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC) or from one Durable Medical Equipment (DME) MAC to another DME MAC (SE0837)

MLN Matters® Number: SE0837
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: This article, SE0837, has been updated and re-issued as SE1017. You can find the updated article at **http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf** on the Centers for Medicare & Medicaid Services website.

Recovery Audit Contractor (RAC) Demonstration High-Risk Vulnerabilities - No Documentation or Insufficient Documentation Submitted (SE1024) (GEN)

MLN Matters® Number: SE1024 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

This is the first in a series of articles that will disseminate information on RAC high dollar improper payment vulnerabilities. The purpose of this article is to provide education regarding RAC demonstration-identified vulnerabilities in an effort to prevent these same problems from occurring in the future. With the expansion of the RAC Program and the initiation of complex medical review (coding and medical necessity) in all four RAC regions, it is essential that providers understand the lessons learned from the demonstration and implement appropriate corrective actions.

Note: *This article was revised on July 14, 2010, to correct the subcontractor information for Diversified Collection Services on page 4. All other information is the same.*

Provider Types Affected
This article is for all Inpatient Hospital and Skilled Nursing Facility providers that submit fee-for-service claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (MACs).

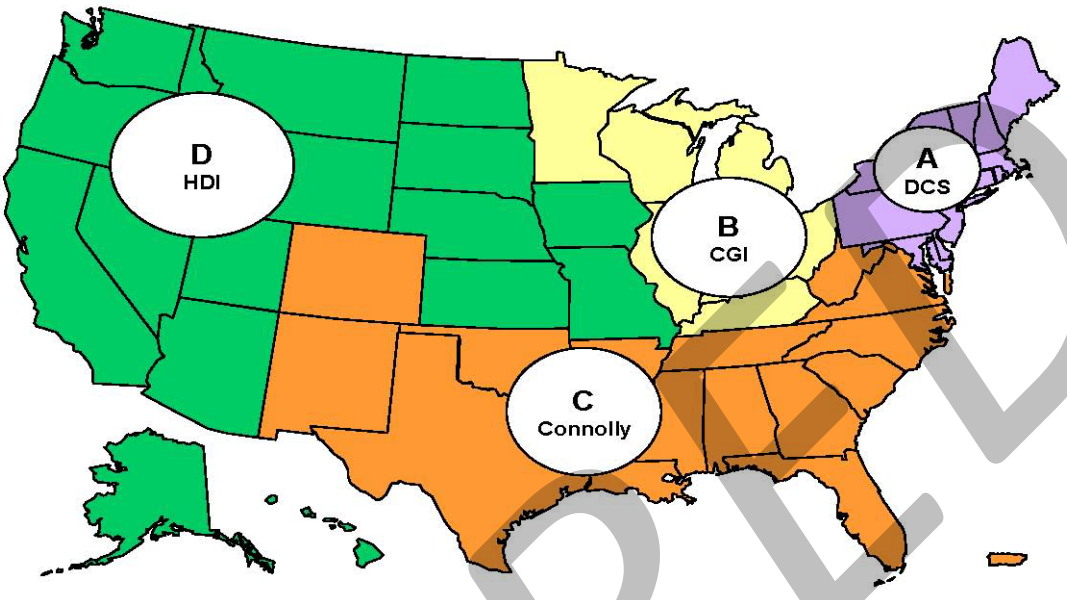
Provider Action Needed
Review the article and take steps, if necessary, to meet Medicare's documentation requirements to avoid unnecessary denial of your claims.

Background
The *Medicare Modernization Act of 2003* (MMA) mandated that the Centers for Medicare & Medicaid Services (CMS) establish the Recovery Audit Contractor (RAC) program as a three-year demonstration. The demonstration began March 2005 in California, Florida, and New York. In 2007, the program expanded to include Massachusetts, Arizona, and South Carolina before ending on March 27, 2008. The success of the demonstration resulted in the passage of legislation in the *Tax Relief and Healthcare Act of 2006, Section 302*, which required CMS to establish a National RAC Program by January 1, 2010.

CMS uses four RACs to implement the National RAC program. Each RAC is responsible for identifying overpayments and underpayments in approximately one quarter of the country. Figure 1 displays each of the four RAC regions and identifies the RAC responsible for recovery activities in that region.
Figure 1: A description of the four RACs and their responsible recovery activities may also be found on pages 3 and 4.

Figure 1:

RAC REGIONS



The primary goal of the RAC demonstration was to determine if recovery auditing could be effective in Medicare. While the demonstration proved recovery auditing was successful identifying and correcting improper payments in Medicare, it also provided best practices for developing a national program and allowed CMS to identify high risk vulnerabilities. Two of the high risk vulnerabilities identified during the RAC demonstration include:

- Provider non-compliance with timely submission of requested medical documentation; and
- Insufficient documentation that did not justify that the services billed were covered, medically necessary, or correctly coded.

Medical Documentation Reminders

CMS reminds providers that medical documentation must be submitted within 45 days of the date of the Additional Documentation Request (ADR) letter. Medicare contractors, including RACs, have the legal authority to review any information, including medical records, pertaining to a Medicare claim. If a provider fails to submit documentation, there is no justification for the services or the level of care billed. Failure to submit medical records (unless an extension has been granted) results in denial of the claim.

Submission of incomplete or illegible medical records can also result in denial of payment for services billed. Claim payment decisions that result from a medical review of records are based on the documentation that Medicare contractors received. For a Medicare claim to be paid, there must be sufficient documentation in the provider's records to verify that the services were provided to eligible beneficiaries, met Medicare coverage and billing requirements, including being reasonable and necessary, were provided at an appropriate level of care and correctly coded. If there is insufficient documentation for the services billed, the claim may be considered an overpayment and the provider may be requested to repay the claim paid amount to Medicare.

Actions to Assist Providers

The following requirements have been developed to assist providers in ensuring the timely submission of sufficient documentation to justify the services billed:

- RACs must clearly indicate deadlines for submission of medical records in ADR letters;
- RACs must initiate one additional contact with the provider before issuing a denial for a failure to submit documentation;
- RACs must accept and review extensions requests if providers are unable to submit documentation timely;
- RACs must clearly indicate in ADR letters suggested documentation that will assist them in adjudicating the claim;
- RACs must allow providers to submit medical records on CD/DVD or to fax the needed medical records;
- RACs must implement the RAC look back date of 3 years with a maximum look back date of October 1, 2007;

- RACs must limit the number of medical records requests every 45 days;
- RACs must indicate the status of a provider's additional documentation requests on their claim status websites;
- RACs must establish a provider web-portal so providers can customize their address and identify an appropriate point of contact to receive ADR letters; and
- RACs must post all approved issues under review on their websites.

Preparing for RAC Audits

CMS recommends providers implement a plan of action for responding to RAC ADR letters. This could involve developing a RAC team to coordinate all RAC activities that may include tracking audit and appeal findings, identifying patterns of error, implementing corrective actions, etc. Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters. Providers should tell the RAC the precise address and contact person to use when sending ADR letters. Providers may submit this information to the RAC. Additional information on how to identify a point of contact can be found on the individual RAC web pages listed at the end of this article. Providers can also check the status of the submitted documentation by accessing the applicable RAC website. This allows providers to track whether the RAC received the documentation. Providers should consult the individual RAC web pages to determine the proper method for accessing this information. Providers should also consider monitoring their RAC websites for updates on approved new issues. This will assist providers in better understanding what audits are taking place so they can prepare to respond to ADR letters.

CMS RAC Website Information

The following list identifies information unique to each of the four RACs, the States they cover, their subcontractor(s), and includes website information to assist providers in preparing for RAC audits:

RAC Region A- Diversified Collection Services (DCS), Inc. of Livermore, California:

- **States in Region:** Maryland (MD), Washington, D.C., Delaware (DE), New Jersey (NJ), Pennsylvania (PA), New York (NY), Maine (ME), Vermont (VT), New Hampshire (NH), Massachusetts (MA), Connecticut (CT), and Rhode Island (RI).
- **Subcontractors:** PRGX (formerly PRG Schultz), Federal Review Services, and iHealth Technologies
- **Email:** **Info@dcsrac.com**
- **Website:** **http://www.dcsrac.com/portal.html**

RAC Region B- CGI Technologies and Solutions, Inc. of Fairfax, Virginia:

- **States in Region:** Michigan (MI), Minnesota (MN), Wisconsin (WI), Illinois (IL), Indiana (IN), Kentucky (KY), and Ohio (OH).
- **Subcontractor:** PRGX
- **Email:** **racb@cgi.com**
- **Website:** **http://racb.cgi.com/**

RAC Region C- Connolly, Inc. of Philadelphia, Pennsylvania:

- **States in Region:** Colorado (CO), New Mexico (NM), Texas (TX), Oklahoma (OK), Arkansas (AR), Louisiana (LA), Mississippi (MS), Tennessee (TN), Alabama (AL), Georgia (GA), North Carolina (NC), South Carolina (SC), West Virginia (WV), Virginia (VA), Florida (FL), US Virgin Islands (VI) and Puerto Rico (PR).
- **Subcontractor:** Viant
- **Email:** **racinfo@connollyhealthcare.com**
- **Website:** **http://www.connollyhealthcare.com/RAC/**

RAC Region D- HealthDataInsights (HDI), Inc. of Las Vegas, Nevada

- **States in Region:** Washington (WA), Oregon (OR), California (CA), Alaska (AK), Hawaii (HI), Nevada (NV), Idaho (ID), Montana (MT), Utah (UT), Arizona (AZ), Wyoming (WY), North Dakota (ND), South Dakota (SD), Nebraska (NE), Kansas (KS), Iowa (IA), and Missouri (MO).
- **Subcontractor:** PRGX
- **Email:** **racinfo@emailhdi.com**
- **Website:** **https://racinfo.healthdatainsights.com/**

Additional Information

Providers are also encouraged to visit the CMS RAC website at **http://www.cms.gov/RAC** for updates on the National RAC Program. On that website, you can register to receive email updates and view current RAC activities nationwide.

Reprocessing of Claims for Certain Replacement Parts, Accessories, or Supplies for Prosthetic Implants and Surgically Implanted Durable Medical Equipment (DME) with Dates of Service of October 27, 2008, through December 31, 2009 (MM6970) (GEN)

MLN Matters® Number: MM6970
Related CR Release Date: June 11, 2010
Related CR Transmittal #: R719OTN

Related Change Request (CR) #: 6970
Effective Date: October 27, 2008
Implementation Date: October 4, 2010

Provider Types Affected
This article impacts DME suppliers billing Medicare Carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for certain replacement parts, accessories, or supplies for prosthetic implants and surgically implanted DME with dates of service of October 27, 2008, through December 31, 2009.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6970 in order to augment previously issued CR 6573. CMS issued CR 6573, Transmittal 531 on August 14, 2009. That CR included a list of Healthcare Common Procedure Coding System (HCPCS) codes that could be billed as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME according to guidelines established by CR 5917. CR 6970 directs Medicare Contractors to **reprocess claims with dates of service October 27, 2008, through December 31, 2009, containing the HCPCS codes found in the attachment to CR 6573**, using the guidelines established by CRs 5917 and 6573. That list is an attachment to CR 6573 at **http://www.cms.gov/Transmittals/downloads/R531OTN.pdf** on the CMS website. Make certain your billing staffs are aware of these adjustments that will be processed later this year.

Background
CR 5917, Transmittal 1603, issued on September 26, 2008, "*Claims Jurisdiction and Enrollment Procedures for Suppliers of Certain Prosthetics, Durable Medical Equipment (DME) and Replacement Parts, Accessories and Supplies*," communicated that entities enrolled with the National Supplier Clearinghouse (NSC) as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier may enroll with and bill to the carrier/A/B MAC replacement parts, accessories, and supplies for prosthetics implants and surgically implanted DME items that are not required to be billed to the Medicare fiscal intermediary. Included with CR 5917 was an excerpt of the 2008 annual jurisdiction list containing HCPCS codes, which CMS instructed at the time may be billed to the carrier/MAC as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME.

CR 6573, Transmittal 531, issued on August 14, 2009, clarified the claims filing jurisdiction and payment policies for DMEPOS items submitted under the guidelines established in CR 5917. CR 6573 also provided an updated list of HCPCS codes that may be billed as a replacement part, accessory, or supply for prosthetic implants and surgically implanted DME, under these guidelines. CR 6573 was effective for DMEPOS claims with dates of service on and after January 1, 2010.

Key Points of CR 6970
- Medicare Contractors will reprocess claims with dates of service of October 27, 2008 through December 31, 2009 containing the HCPCS codes found in Attachment A of CR 6573, using the claims processing instructions previously communicated in CRs 5917 and 6573.
- CR 6970 and the billing guidelines for replacement parts, accessories and supplies for implanted devices established in CRs 5917 and 6573 apply only to DMEPOS suppliers enrolled with the NSC and their local carrier/A/B MAC and does not change the existing carrier/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 Medicare Carrier or A/B MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction (CR6970) issued to your Medicare Carrier or A/B MAC is available at **http://www.cms.gov/Transmittals/downloads/R719OTN.pdf** on the CMS website.

CR 6573 contains the **2008 DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME** (Rev. March 2009) and that list is an attachment to CR 6573 at **http://www.cms.gov/Transmittals/downloads/R531OTN.pdf** on the CMS website.

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

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

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

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

Note: *This article was revised on June 16, 2010 to include on pages 6-7 a table excerpted from CR 6698 that summarizes signature requirements. All other information is the same.*

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

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

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

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

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

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

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the *Medicare Benefit Policy Manual*, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the

signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g.MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
    - In the situations where the guidelines indicate "**signature requirements met,**" the reviewer will consider the entry.

    - In situations where the guidelines indicate "**contact provider and ask a non-standard follow up question,**" the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)

    - In the situations where the guidelines indicate "**signature requirements NOT met,**" the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic Prescribing

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

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

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

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

- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified E-Prescribing system, the reviewer shall NOT require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional Information
CR 6698 includes a helpful table that summarizes the situations where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit an attestation statement or signature log. Key portions of that table are as follows:

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation **is accompanied** by: 1. a signature log, or 2. an attestation statement	X	
6	Illegible Signature NOT over a typed/printed name, NOT on letterhead and the documentation is **UNaccompanied by**: a. a signature log, or b. an attestation statement		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but **accompanied** by: a. a signature log, or b. an attestation statement	X	
9	Initials NOT over a typed/printed name **UNaccompanied** by: a. a signature log, or b. an attestation statement		X
10	Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

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

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

Timely Claims Filing: Additional Instructions (MM7080) (GEN)

MLN Matters® Number: MM7080
Related CR Release Date: July 30, 2010
Related CR Transmittal #: R734OTN

Related Change Request (CR) #: 7080
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7080 to expand the Medicare Fee-for-Service (FFS) reimbursement instructions outlined in change request (CR) 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. CR 7080 lists the standards for dates of service used to determine the timely filing of claims. Be sure your billing staffs are aware of these changes.

Background
CMS is addressing institutional claims and professional/supplier claims differently with respect to span date claims. Institutions often bill for extended length of stays that exceed a month's (or more) duration. Therefore, it is both less burdensome and more reasonable to use the claim's "Through" date rather than the "From" date as the date of service for determining claims filing timeliness.

Conversely, for physicians and other suppliers that bill claims with span dates, these span date services cannot exceed one month. Thus, there is no compelling need to create an extended filing period. CMS also notes that, if the "From" date of these span date services is timely, then those services billed within the span are timely as well, and this will generally ease the administrative burden of the claims processing contractors in their determination of timely filed claims. Therefore, the "From" date standard will be used for determining claims filing timeliness for physicians and other suppliers that bill claims with span date services. With respect to supplies and rental items, they are physically furnished at or near the beginning of the span dates on the claim. Therefore, the "From" date standard reflects more precisely when the supply or item was delivered to the beneficiary, and will be used as the date for determining claims filing timeliness.

Key Points of CR 7080

- For **institutional claims** that include span dates of service (i.e., a "From" and "Through" date span on the claim), **the "Through" date on the claim will be used to determine the date of service for claims filing timeliness.**
- For **professional claims (CMS-1500 Form and 837P)** submitted by physicians and other suppliers that include span dates of service, the line item **"From" date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).**
- **BE AWARE:** If a line item "From" date is not timely, but the "To" date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.
- Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed. If the date of service is February 29th of any year and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional Information
Remember CR6960 established that Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

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

You can find the official instruction, CR7080, issued to your carrier, FI, A/B MAC, or RHHI by visiting **http://www.cms.gov/Transmittals/downloads/R734OTN.pdf** on the CMS website. If you have any questions, please contact your FI, MAC, or RHHI at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

To review MM6960, *Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months*, you may go to **http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf** on the CMS website.

CMS News Flash (GEN)

On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced two complementary final rules to implement the electronic health records (EHR) incentive program under the Health Information Technology for Economic and Clinical Health (HITECH) Act. Announcement of these regulations marks the completion of multiple steps laying the groundwork for the incentive payments program. To learn more about the Medicare and Medicaid EHR incentive programs, visit the CMS-dedicated website for this program at **http://www.cms.gov/EHRIncentivePrograms/** on the CMS website.

On June 18, 2010, the Office of the National Coordinator for Health Information Technology (ONC) issued a final rule to establish a temporary certification program for electronic health record (EHR) technology. To see the press release related to this rule, visit **http://www.hhs.gov/news/press/2010pres/06/20100618d.html** on the Internet.

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

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

The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work - approximately 15 work days after Medicare's reimbursement is made, as stated in MLN Matters Article SE0909 (**http://www.cms.gov/MLNMattersArticles/downloads/SE0909.pdf**) - before attempting to balance bill their patients' supplemental insurers. That is, do not balance bill until you have received written confirmation from Medicare that your patients' claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare's intention to cross your patients' claims over.

The Centers for Medicare & Medicaid Services (CMS) has released MLN Matters Special Edition Article #SE1017 to assist all providers that will be affected by Medicare Administrative Contractor (MAC) implementations, or DME MAC transitions due to re-competing DME MAC Contracts. This article updates material contained in MLN Matters Article #SE0837, which was originally issued in November 2008, to reflect current experiences with transitions to a MAC. For more details, please read the article at **http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf** on the CMS website.

The Centers for Medicare & Medicaid Services (CMS) has posted on its website 11 new frequently asked questions (FAQ) about the ICD-10 Implementation. To access these FAQs, please visit the CMS ICD-10 webpage at **http://www.cms.gov/ICD10/**, select the Medicare Fee-for-Service Provider Resources link on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

General Information

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

The Medicare Preventive Services Resources CD, which contains PDF files of our Medicare Preventive Services educational products on a single convenient CD Rom, is now available for order through the Medicare Learning Network - free of charge! To order a free copy of the CD, please visit the Preventive Services Educational Products page at **http://www.cms.gov/MLNProducts/35_PreventiveServices.asp** on the CMS website. Scroll down to the "Related Links Inside CMS" section and click on "MLN Product Ordering".

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

Beginning with the April 2010 update, the Centers for Medicare and Medicaid Services (CMS) will now post the National Correct Coding Initiative (NCCI) Edit files in Excel 2007 and in text formats. Because Excel 2007 can support a larger number of rows, each code range will be contained in one file as opposed to multiple files. This should correct the incompatibility issues that some users experienced last quarter with the Excel 2003 files. Please be aware that Excel 2003 and earlier versions of the software have a maximum row count of 65,536. Some of the NCCI Edit files exceed the maximum row count. If you do not have Excel 2007, please use the text format to import the data into an application that can support larger files. For more information on NCCI edits and to download the files, visit **http://www.cms.gov/NationalCorrectCodInitEd/** on the CMS website.

Do you ever wonder about how to utilize search tools in selected areas of the CMS website? The searchable Medicare Coverage Database (MCD) contains all Medicare National Coverage Determinations (NCDs), National Coverage Analyses (NCAs), Local Coverage Determinations (LCDs), and local policy articles. The Medicare Learning Network (MLN) has produced a "How To" booklet (2.5 MB), that provides an explanation of the MCD, as well as how to use the Search, Indexes, Reports and Downloads features. The revised How to Use the Medicare Coverage Database booklet is available at **http://www.cms.gov/MLNProducts/MPUB/list.asp** on the MLN Publications page. Use search key words "how to" to locate this publication quickly. Understanding the search tool is the best way to find the information for which you are looking!

Declare your independence from the paper enrollment process - use Internet-based PECOS! Learn how at **http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp** on the Centers for Medicare & Medicaid website.

Internet-based provider enrollment is easy and quick! Submit initial Medicare PECOS applications online up to 50% faster than on paper! Learn more at **https://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp** on the CMS website.

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

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

Remember: The Transition to ICD-10 is Coming October 1, 2013 - there will be no Extension. On October 1, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets. ICD-10-CM diagnoses codes will be used by all providers in every health care setting. ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures. The compliance dates are firm and not subject to change. There will be no delays. There will be no grace period for implementation. For more information about ICD-10 Implementation, please read MLN Matters® Special Edition article SE1019 located at

http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf on the CMS website.

Remember: The Transition to ICD-10 is Coming October 1, 2013 - On October 1, 2013, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues. Ask your clearinghouse, billing service or software vendor what you need to do to be ready for ICD-10. For more information about ICD-10 Implementation, please read MLN Matters® Special Edition article SE1019 located at **http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf** on the CMS website.

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.gov/mcd/overview.asp

Correct Coding for Pneumatic Compression Devices (SPE)

Pneumatic compression devices (PCD) consist of an inflatable garment for the arm or leg and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary between devices. Several categories of these devices exist. It is important to use the correct HCPCS code for the item provided.

PCDs used for the treatment of lymphedema and chronic venous insufficiency with ulcers are coded based upon the characteristics of the base device. The codes used are:

E0650 - PNEUMATIC COMPRESSOR, NON-SEGMENTAL HOME MODEL
E0651 - PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITHOUT CALIBRATED GRADIENT PRESSURE
E0652 - PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL WITH CALIBRATED GRADIENT PRESSURE

PCDs used for the treatment of arterial disease are coded:

E0675 - PNEUMATIC COMPRESSION DEVICE, HIGH PRESSURE, RAPID INFLATION/DEFLATION CYCLE FOR ARTERIAL INSUFFICIENCY (UNILATERAL AND BILATERAL SYSTEM)

Sleeves used with E0650 - E0652 and E0675 are billed separately using codes E0655 - E0673 depending upon the specific item provided.

There are other types of PCDs that are often referred to as deep vein thrombosis (DVT) pumps, massage therapy pumps, post surgical DVT preventative pumps, etc. (not all inclusive). These types of devices are coded:

E0676 - INTERMITTENT LIMB COMPRESSION DEVICE (INCLUDES ALL ACCESSORIES), NOT OTHERWISE SPECIFIED

The garments/sleeves that are used with E0676 are included in the payment for E0676 and must not be billed separately. If a supplier chooses to bill separately for the garment/sleeve, then HCPCS code A9900 - MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE must be used.

HCPCS code A4600 - SLEEVE FOR INTERMITTENT LIMB COMPRESSION DEVICE, REPLACEMENT ONLY, EACH is used only when the sleeve is being replaced, not at the time of initial issue. This code may only be used with compressors coded with E0676. HCPCS codes E0655 - E0673 must not be used when billing for garments used with E0676 devices.

Refer to the Local Coverage Determination (LCD) and Policy Article for Pneumatic Compression Devices for coverage and HCPCS coding requirements.

Immunosuppressive Drugs - Everolimus (Zortress®) (DRU)

The Food and Drug Administration has approved the use of everolimus (Zortress®) tablets as prophylaxis for rejection of organ transplants. Coverage is effective for claims with dates of service on or after April 20, 2010.

Everolimus is supplied as tablets, 0.25 mg, 0.5 mg, and 0.75 mg. Until such time as an individual HCPCS code is designated, claims should be billed using HCPCS code J7599 IMMUNOSUPPRESSIVE DRUG, NOT OTHERWISE CLASSIFIED. One unit of service is 0.25 mg. As indicated in the Immunosuppressive Drugs LCD, "(When) code J7599 is billed, the claim must list the name of the drug, the dosage strength, number dispensed and administration instructions."

Refer to the *Immunosuppressive Drugs LCD* for modifier and additional coverage requirements. Everolimus will be added to a future revision of the LCD.

Oral Anticancer Drugs - Covered Diagnoses (DRU)

In March 2010, a revised *Oral Anticancer Drugs Policy Article* was published with an effective date of June 01, 2010. That policy revision defined the ICD-9 diagnosis codes for which each drug would be covered. The DME MAC medical directors have received a number of requests for reconsideration of the policy to add additional diagnosis codes. A revision of the Policy Article with an expanded list of covered diagnoses will be published in the near future. Coverage of the additional diagnoses will be retroactive to the June 1 effective date of the current policy.

Oral Anticancer Drugs - Covered Diagnoses (DRU)

In March 2010, a revised medical policy on Oral Anticancer Drugs was published with an effective date of June 1, 2010. That policy revision defined the ICD-9 diagnosis codes for which each drug would be covered. The policy was revised to be consistent with Medicare's national coverage policy for Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen. That policy is found in the *Medicare Benefit Policy Manual*, Publication # 100-02, Chapter 15, Section 50.4.5: **http://www.cms.gov/Manuals/IOM/list.asp**

That policy states that off-label indications are covered in two general situations:

1. The use is (a) supported in any of the following four compendia:
   - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium - Category 1 or 2A
   - American Hospital Formulary Service - Drug Information
   - Thomson Micromedex DrugDex - Class I, IIa, or IIb
   - Clinical Pharmacology

   and (b) not listed as unsupported/not medically accepted in any of the compendia (e.g., Category 3 in NCCN or Class III in DrugDex).

2. The Medicare contractor makes a determination based on its analysis of the published literature from one or more of the 26 journals listed in that section.

A further revision of the Oral Anticancer Drugs Policy Article is being released with the addition of a number of ICD-9 codes. The effective date of this expanded list of diagnosis codes is retroactive to June 1.

If suppliers or physicians think that there are additional diagnoses that meet the criteria defined in the *Medicare Benefit Policy Manual*, they may send documentation to:

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

The documentation should be copies of either the pertinent sections of one of the four compendia or full text versions of published articles from the specified journals.

The preference is that these be electronic documents submitted on a disc; however, hard copy printouts are also acceptable.

Suppliers should refer to the Oral Anticancer Drugs Local Coverage Determination and Policy Article for complete information concerning coverage criteria, coding guidelines, and documentation requirements.

PAP Documentation Requirement Revision - Ineffective Therapy on E0601 (SPE)

Recently questions have been received by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) medical directors regarding the requirements in the Positive Airway Pressure (PAP) local coverage determination (LCD) for documentation of ineffective therapy while on an E0601 device. To clarify when a patient may switch from an E0601 to an E0470 device, the following language will replace the current verbiage in the Documentation Requirements section in an upcoming revision of the PAP LCD. The change will be effective for dates of service on or after August 1, 2010.

Revised Language:
For beneficiaries changing from an E0601 to E0470 due to ineffective therapy while on E0601 (either during a facility-based titration or in the home setting), the treating physician must document that both of the following issues were addressed prior to changing to an E0470 device:

A. Interface fit and comfort. An appropriate interface has been properly fit and the beneficiary is using it without difficulty. This properly fit interface will be used with the E0470 device; and,
B. E0601 pressure settings. The current pressure setting of the E0601 prevents the beneficiary from tolerating the therapy and lower pressure settings of the E0601 were tried but failed to:
    1. Adequately control the symptoms of OSA; or,
    2. Improve sleep quality; or,
    3. Reduce the AHI/RDI to acceptable levels.

For additional coverage, coding and documentation requirements, suppliers should refer to the PAP LCD and related Policy Article on the DME MAC Web sites.

Pneumatic Knee Splint - Coding Verification Review Requirement (O&P)

Effective for claims with dates of service on or after January 01, 2011, the only products which may be billed using code L4380 (Pneumatic knee splint, prefabricated, includes fitting and adjustment) are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor.

Information concerning the documentation that must be submitted to the PDAC for a Coding Verification Request can be found on the PDAC web site **http://www.dmepdac.com/review/index.html** or by contacting the PDAC Contact Center at 877.735.1326. Once the products are coded by the PDAC they will be listed on the Product Classification List.

Policy Article Revisions - Summary for August 2010 (GEN)

Outlined below are the principal changes for two Policy Articles (PAs) that have been revised and posted. Please review the entire Policy Articles for complete information.

Oral Anticancer Drugs

Policy Article

Revision Effective Date: 06/01/2010 (August Publication)

ICD-9 CODES THAT ARE COVERED:

Added: Multiple diagnoses for all the drugs.

Oxygen and Oxygen Equipment

Policy Article

Revision Effective Date: 07/01/2010

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Coverage for maintenance and servicing, months 37-60.

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

Power Mobility Devices FAQ - Supplier ATP Involvement (Revised July 2010) (MOB)

This is a revision of an article originally published in 2008 and revised in December 2009. It clarifies the requirement in the Power Mobility Devices (PMD) Local Coverage Determination (LCD) that the supplier of a rehab PMD must employ a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient. The term rehab PMD includes Group 2 power wheelchairs (PWCs) with power seating options, all Group 3, 4, and 5 PWCs, and push-rim power assist devices. The response to Q3 has been revised to clarify supplier requirements relating to the DMEPOS Quality Standards.

Q1: What is an ATP?

A1: An Assistive Technology Professional (ATP) is a designation of certification by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). Prior to January 1, 2009, RESNA maintained two certifications - Assistive Technology Supplier (ATS) and Assistive Technology Practitioner (ATP). Those certifications were combined into one - Assistive Technology Professional (ATP) - with a single certification examination after January 1, 2009. An ATP is a service provider who analyzes the needs of individuals with disabilities, assists in the selection of appropriate equipment and trains the consumer on how to properly use the specific equipment.

Q2: Why does Medicare require "in-person" involvement in the selection of a rehab wheelchair?

A2: As one can see from the description of the ATP in Question 1, the sATP with experience and training in proper assistive technology selection is in an ideal situation to translate the functional information from the licensed certified healthcare professional (LCMP) specialty examination into a specific equipment selection for the beneficiary.

Q3: Clarify "employ" as it relates to an ATP within this policy.

A3: The DMEPOS Quality Standards require that a supplier of complex rehab wheelchairs employ (W-2 employee) an individual who has one of the following credentials: ATP or CRTS (Certified Rehabilitative Technology Supplier). This individual may not be a "contract" employee.

However, the supplier could employ additional ATPs to meet the sATP requirement in the PMD LCD. Those additional sATPs could be employed in a full-time, part-time, or contracted capacity, as is acceptable by state law. Those sATPs, if part-time or contracted, must be under the direct control of the supplier when participating in the wheelchair selection.

Q4: If a supplier has a part time or contracted ATP on staff, what type of special documentation would be needed in an audit to prove the credential?

A4: A supplier must show that the employee was working under the supplier's control and guidance. The supplier should also be able to provide evidence of the sATP certification upon request.

Q5: Would a supplier be asked to provide employment records in an MR audit?

A5: Yes, employment records, contracting agreements or credential records could be requested. These types of records do not need to be routinely submitted with a claim but must be available upon request.

Q6: What does it mean for the sATP to have direct, in-person involvement in the wheelchair selection process?

A6: It means to physically see and interact with the patient and to document that involvement. It is important that the record show how the sATP was involved.

Q7: Can the sATP sign off on the licensed/certified medical professional (LCMP) evaluation, detailed product description, or some other attestation to demonstrate compliance with the requirement?

A7: The medical policy does not mandate how suppliers document compliance with the ATP requirement. There must be evidence in the supplier's file of direct in-person interaction with the patient by the sATP in the wheelchair selection process. The supplier, LCMP or treating physician must document how the sATP is involved with the patient. The documentation must be complete and detailed enough so a third party would be able to understand the nature of the sATP involvement and to show that the standard was met. Just "signing off" on a form completed by another individual would not adequately document direct, in-person involvement. For example, if the sATP participates in the specialty evaluation conducted in a multi-specialty clinic, the sATP could request that the person conducting and documenting the specialty evaluation include their name and credentials in the final report - "Ms. Jones was evaluated today for a power mobility device. Taking part in the evaluation was Dr. Smith, Ann Jones, PT, and Bill Doe, ATP from XYZ Mobility." As an alternative, the sATP can create a note documenting their involvement in the specialty evaluation process and that the recommendations reflect their input.

Q8: If the sATP is not present at the specialty evaluation with the therapist or physiatrist, but does assess the patient "in person" following the evaluation by the LCMP, such as during the home evaluation, does this fulfill the requirement for "involvement with the selection process"?

A8: If the sATP has direct contact with the patient and has been involved in the wheelchair selection process, the requirement is met, providing that the sATP interaction is clearly documented within the patient's file. If the sATP has not had direct in-person involvement in the wheelchair selection process, the requirement is not met and the KX modifier must NOT be added to the code.

Q9: How should the sATP document their involvement if their evaluation takes place at the office or the beneficiary's home?

A9: A critical component in the provision of a PMD is ensuring that the wheelchair and accessories selected are appropriate for the beneficiary and meet their unique, individual needs. This often includes taking trunk and limb measurements, seating and positioning needs, and other observations about the beneficiary and their ability to use a PMD. This interaction should be documented by the sATP conducting the evaluation and signed and dated by the sATP, including their credentials.

Q10: Must the sATP be present for the delivery, fitting, and/or patient training for the wheelchair provided?

A10: The policy states that the credentialed sATP must have direct, in-person involvement with the equipment selection process. The policy does not require that the sATP be present for delivery, fitting, and/or patient training for the wheelchair.

Q11: Can the sATP evaluation be conducted at the time of the PMD delivery to the beneficiary?

A11: No. The purpose of the sATP evaluation is determining the proper seating, accessories and other components of the PMD prior to ordering and delivery; therefore, conducting this evaluation at the time of delivery of the device to the beneficiary's residence is not consistent with the intent of this requirement.

Q12: A company employs an ATP, as well as a number of non-credentialed staff who have direct, in-person involvement with the selection process. Is it permissible for the sATP to review the staff's recommendations and sign concurrence to meet the requirement?

A12: The sATP must have direct in-person involvement with the wheelchair selection process. An sATP cannot simply "review" and "sign off" on non-credentialed staff work in order to meet the requirement.

Q13: Can the sATP select a product prior to the face-to-face (F2F) examination by the physician and/or prior to the specialty evaluation by the LCMP?

A13: Since the role of the sATP is to assure that the equipment selected is appropriate to address the medical needs identified during the F2F examination and specialty evaluation process, it would be inappropriate to begin product selection prior to completion of the F2F examination or specialty evaluation. Any in-person sATP/beneficiary interactions prior to the F2F examination or specialty evaluation would not be considered sufficient to meet the LCD requirement.

Q14: An ATP candidate has taken the RESNA exam but at the time of the in-person evaluation has not yet received the credential. In the event of an audit, will the pending receipt of the sATP credential, retroactively dated to the day the test was taken, be considered compliant?

A14: The LCD requires that there must have been an evaluation by a properly credentialed, supplier-employed ATP. The sATP must have been certified as of the date he/she performed the in-person evaluation of the patient. The sATP is not a credentialed ATP until receipt of the credential from RESNA. The RESNA document will specify the effective date of the credential.

Q15: If an ATP employed by a supplier who has had direct in-person involvement in the wheelchair selection process for a patient leaves a company before the wheelchair is delivered, will the claim be considered compliant?

A15: Leaving the company employment would not invalidate what that person did while working as a RESNA-certified ATP. The patient's record must illustrate the previously employed sATP had in-person involvement with the wheelchair selection process.

Q16: Can an sATP perform any part of the F2F examination process required for all PMDs or the specialty evaluation required for rehab wheelchairs?

A16: No.

Q17: If the sATP participated in the evaluation by means of a live video feed, would that be acceptable?

A17: Yes. Involvement of the sATP in the evaluation of the patient via a live video feed is acceptable for beneficiaries who reside in remote locations as long as the evaluation is conducted in accordance with the Telehealth requirements outlined in the Centers for Medicare and Medicaid Services (CMS) *Benefit Policy Manual* (Internet-Only Manual 100-2), Chapter 15, Section 270.

Power Wheelchair Electronics Clarification (MOB)

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

When one power seating function/actuator/motor is provided on a power wheelchair, one unit of E2310 (electronic connection between wheelchair controller and one power seating system motor) is allowed. An expandable controller (E2377) and harness (E2313) are not allowed in this situation unless a specialty interface is used.

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

When two power seating functions/actuators/motors are provided, one unit of E2311 (electronic connection between wheelchair controller and two or more power seating system motors) is allowed. An expandable controller (E2377) and harness (E2313) are not allowed in this situation unless a specialty interface is used.

Example: E1006 (Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction) is added to a power wheelchair. The tilt and the recline functions each have one actuator or power seating system motor, for a total of two.

When three or more power seating functions/actuators/motors are provided, one unit of E2311 (electronic connection between wheelchair controller and two or more power seating system motors), one unit of E2377 (expandable controller), and one unit of E2313 (harness for upgrade to expandable controller) are allowed.

Example: E1008 (Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction) is added to a power wheelchair. The tilt, recline, and power shear reduction features each have one actuator or power seating system motor, for a total of three.

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

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

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

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

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

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

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

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

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

The DME MAC Jurisdiction A has completed the first quarter prepayment review of claims for *Nebulizers LCD* (L11499). The first quarterly findings have included claims with dates of service from September 2009 through April 2010. This review evaluated claims for HCPCS code E0570 (NEBULIZER, WITH COMPRESSOR).

The review involved prepayment complex medical review of 100 claims submitted by 62 suppliers, of which, 48 claims were allowed and 52 were denied, resulting in a 52% Claim Denial Rate. Consequently, the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 43%.

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

- Insufficient medical records (34%)
  - Incomplete diagnosis or condition
  - Missing prescription or missing refill prescription
  - Missing inhalant drugs and amount of solution
  - Missing delivery tickets or missing signature of delivery slip
- No response received to request for medical records (18%)

Documentation must include:

- A detailed order that includes the following:
  - Patient name
  - The description of item to be dispensed
  - The type of solution
  - Administration instructions:
    - Amount of solution
    - Frequency of use
  - The ordering physician's legible signature
  - The date of the ordering physician's signature

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

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

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

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

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

Results of Widespread Prepayment Review of Claims for HCPCS Codes A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Patients) (SPE)

The DME MAC Jurisdiction A has completed the prepayment review of claims for A4623 and A4629. This review was initiated due to the results of the quarterly review of dollars allowed trends that indicated high volume claims for these two codes.

The review involved prepayment complex medical review of 100 claims submitted by 42 suppliers, of which, 35 claims were allowed as billed and 65claims were denied resulting in a claim denial rate of 65%. Consequently, the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 66.86%.

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

- Service determined to be medically unnecessary (27%):
  - No MD orders
  - No medical records from ordering physician(s); other pertinent documentation that would support the medical necessity of the item(s) billed
  - No other substantiating documentation (e.g., delivery tickets (no date), invoice including manufacturer's name and model numbers
  - Duplicate submission
  - Service denied as duplicate, previously considered
- Requested medical documentation not received (38%):
  - Service denied as requested documentation not received (17 of 42 suppliers did not submit medical records as requested).

The most common problem involved is the suppliers' non-response to requests for medical records. Of the services denied as not medically necessary (27%), there was for the most part missing or incomplete records such as no orders on record, missing or incomplete records - no medical record that contain information about the items used and/or the underlying medical condition/documentation that would support the medical necessity, missing delivery tickets.

Suppliers are reminded that documentation must be available to the DME MAC upon request. Suppliers should be aware of Documentation Requirements provided in the *DME MAC Jurisdiction A Supplier Manual*, Chapter 10 - Documentation Requirements, which states the following:

> "*For any DMEPOS item to be covered by Medicare, the patient's medical record **must** contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but **not** limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN, it is recommended that a copy of the completed CMN be kept in the patient's record. However, neither a physician's order nor a CMN nor a supplier-prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician. There **must** be clinical information in the patient's medical record that supports the medical necessity for the item **and** substantiates the answers on the CMN (if applicable), or information on a supplier-prepared statement or physician attestation (if applicable).*
>
> *The patient's medical record is **not** limited to the physician's office records. It may include hospital, nursing home, or home health agency (HHA) records, and records from other professionals including, but **not** limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.*
>
> *The documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DME MAC. However, the DME MAC may request this information in selected cases. If the DME MAC or does **not** receive the information when requested, or if the information in the patient's medical record does **not** adequately support the medical necessity for the item, then on assigned claims, the supplier is liable for the dollar amount involved, unless a properly executed ABN of possible denial has been obtained.*"

It is the suppliers' responsibility to provide sufficient documentation to support the medical necessity of the item(s) billed to the DME MAC. Suppliers should maintain these records on file and be made available upon request of the DME MAC for specific reviews.

Suppliers operating within Jurisdiction A's service area must respond to documentation requests in a timely manner upon notification from the DME MAC. Suppliers are also encouraged to visit the DME MAC Jurisdiction A web site at **http://www.medicarenhic.com/dme** on a regular basis to remain current with the latest information regarding Tracheostomy Care Supplies and the LCDs for Jurisdiction A.

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

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from January 01, 2010 through March 31, 2010 and resulted in a 45.7% Charge Denial Rate (CDR).

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

- This review involved prepayment complex medical review of 1000 claims submitted by 394 suppliers, of which, 237 claims were allowed and 763 were denied resulting in a claim denial rate of 76.3%. Consequently, the total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 75.3%.

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

- Incomplete documentation (78.9%)
  - One or more document not provided; no 7 element order / prescription; no detail product description; no physician Face to Face examination / mobility evaluation; no home evaluation / assessment; no LCMP; no attestation of financial relationship.
  - 7 element order / prescription missing one or more elements (date of face to face, length of need, description of item, etc.), pre-printed "power mobility device" already entered.
  - Detail product description not signed or signature and/or date illegible, allowance amounts not included, dated prior to completion of face to face / mobility evaluation.
  - No received date indicators on documents.
- Determined to be medically unnecessary (16%)
  - Face to Face; not a physical exam; did not address mobility issue; only attesting to agree with PT evaluation;
  - Upper extremity / lower extremity issues not addressed.
  - ROM and strength indicated did not justify PMD.
  - Insufficient documentation submitted to establish medical necessity for PMD.
  - Patient appears to be able to ambulate, utilize walker and/or manual wheelchair.
- Other (5.1%)
  - Duplicate claim submission.
  - Late claim filing.
  - Wheelchair returned to supplier.
  - Claim billed in error.

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

Suppliers are reminded to reference the following publications for documentation requirements.
The January 11, 2008 educational article *Power Mobility Devices Billing Reminder* (**http://www.medicarenhic.com/dme/articles/011108_pmd.pdf**),
November 05, 2009 educational article *Power Mobility Devices - 7-Element Order*

(**http://www.medicarenhic.com/dme/medical_review_bulletin_current/110509_7-element-order.pdf**),
and the *Power Mobility Devices (L21271)* LCD (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**).

Therapeutic Shoes - Policy Revision/ Documentation Requirements (O&P)

A revision of the Therapeutic Shoes Policy Article (PA) has been released. In addition, the following revision to the Documentation Requirements section of the LCD is being made. It will be incorporated in a subsequent revision of the Therapeutic Shoes LCD.

An order for each item billed must be signed and dated by the prescribing physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

If the prescribing physician is the supplier, a separate order is not required, but the item provided must be clearly noted in the patient's record.

A new order is not required for the replacement of an insert or modification within one year of the order on file. However, the supplier's records should document the reason for the replacement. A new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file. For claims with dates of service on or after January 1, 2011, the detailed written order must be signed on or after the date of the visit with the Prescribing Physician (see related Policy Article for information about the visit with the Prescribing Physician).

The supplier must obtain a signed statement from the physician who is managing the patient's systemic diabetes condition (i.e., the certifying physician) specifying that the patient has diabetes mellitus, has one of conditions 2a-2f listed in the related Policy Article, is being treated under a comprehensive plan of care for his/her diabetes, and needs diabetic shoes. The certifying physician must be an M.D. or D.O and may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist. The "Statement of Certifying Physician for Therapeutic Shoes" form (see LCD Attachments section below) is recommended. Whatever form is used must contain all of the elements contained on the recommended form attached to this LCD. This statement must be completed, signed, and dated by the certifying physician and must be received by the supplier prior to claim submission. A new Certification Statement is required for a shoe, insert or modification provided more than one year after the most recent Certification Statement on file.

There must be information in the medical records of the certifying physician that:

a. Documents management of the patient's diabetes; and
b. Documents detailed information about the condition (2a-2f listed in the related Policy Article) that qualifies the patient for coverage.

The Certification Statement by itself does not meet this requirement for documentation in the medical records.

The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 4) must include at least the following:

1. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient's feet.
3. For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's fee that will be used in creating positive models of the feet.

The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

The ICD-9 code that justifies the need for these items must be included on the claim.

These revisions address two main areas:

- In-person fitting and delivery. This requirement is included in the DMEPOS Quality Standards published in October 2008. This policy revision incorporates information that was published in an article in May 2010.
- Certification statement. The Medicare statute - Social Security Act, Title XVIII, Section 1861(s)(12) - states that the physician who is managing the individual's diabetic condition must (1) document that the patient has one of several specified conditions that predispose the patient to diabetic ulcers of the feet and (2) certify that the individual needs therapeutic shoes and inserts under a comprehensive plan of care related to their diabetes. The DME MACs have received a number of questions relating to the timing and sequencing of visits and other activities related to this requirement. The policy revision clarifies these requirements.

The statute, national policy, and LCD/PA identify three entities involved in the provision of therapeutic shoes: Certifying Physician, Prescribing Physician, and Supplier. Definitions of these entities are found in the Therapeutic Shoes Policy Article. The following table summarizes the sequence and timing of the various steps required for the coverage of therapeutic shoes and inserts.

Note: *The information contained in this article is only a summary of requirements. For complete information, you must review the entire LCD and Policy Article.*

	Activity	Responsible Person	Requirements[1]
1	Visit to document diabetes management[2]	Certifying MD/DO	Within 6 months prior to delivery
2	Visit to document qualifying foot condition[2]	Certifying MD/DO, other MD/DO, DPM, PA, NP, CNS	Within 6 months prior to delivery
3	Completing Certification Statement	Certifying MD/DO	After visit(s) to document diabetes management and qualifying foot condition[2] After Certifying Physician reviews and signs report of visit documenting qualifying foot condition by other MD/DO, DPM, PA, NP, CNS - if applicable[3] Prior to initial provision of shoes and inserts For subsequent provision of shoes and inserts, required if delivery is more than 1 year after most recent Certification Statement
4	Providing dispensing order to supplier[4]	Prescribing physician	After visit with Prescribing physician Before delivery
5	Signing detailed written order	Prescribing physician	After visit with Prescribing physician
6	Selection visit	Supplier	
7	Delivery visit	Supplier	After selection visit After receiving dispensing order or detailed written order
8	Submitting claim	Supplier	After delivery After receiving detailed written order After receiving Certification Statement

1 If the table states that one event needs to occur "before" or "after" another event, both could occur on the same date if that sequence was followed
2 Effective for dates of service on/after 1/1/2011
3 Applicable if qualifying foot condition is not documented on visit with Certifying Physician
4 Separate dispensing order not needed if detailed written order received by supplier prior to delivery

Treprostinil Inhalation Solution (Tyvaso®) - Coding and Coverage (SPE)

Effective for dates of service on or after July 31, 2009 treprostinil inhalation solution and the nebulizer and related accessories used to administer it are covered for the treatment of patients with primary pulmonary hypertension (ICD-9 diagnosis codes 416.0 and 416.8) and who meet the criteria for iloprost as described in the Nebulizers LCD.

Treprostinil inhalation solution is coded J7699KO. One unit of service equals one ampule. The claim should identify the name of the drug and the number of ampules dispensed. The submitted charge for J7699KO should just reflect the drug itself - not the nebulizer or accessories.

The Optineb® ir (Nebu-tec) nebulizer used to administer treprostinil inhalation should be billed with code E0574 (ultrasonic nebulizer). Because E0574 is in the capped rental category, in order for it to be paid by Medicare, it must be billed as a rental (RR modifier). If the Optineb® ir nebulizer is billed as a purchase (NU modifier), it will be denied and the drugs and accessories will also be denied. The submitted charge for code E0574 should just reflect the charges for the nebulizer - not the drug or accessories.

If two Optineb® ir nebulizers are provided and the submitted charges reflect two nebulizers, you must bill 2 units of service on the claim line for E0574RR. Medicare will only pay for one nebulizer.

Accessories used in conjunction with the Optineb® ir nebulizer should be billed on separate claim lines. The dome and mouthpiece should be billed with code A7016. Other accessories should be billed with code A9999. When code A9999 is used, the claim must clearly describe the type and quantity of accessories provided.

This information will be added to the next revision of the Nebulizers policy. For additional coverage, coding, and documentation requirements, suppliers should refer to the Nebulizer LCD and related Policy Article on the DME MAC web sites.

Urethral Inserts - A4336 - Coverage and Documentation (SPE)

Urethral inserts (A4336) are covered for adult females with stress incontinence when basic coverage criteria are met and the patient or caregiver can perform the procedure. They are not indicated for women:

- With bladder or other urinary tract infections (UTI)
- With a history of urethral stricture, bladder augmentation, pelvic radiation or other conditions where urethral catheterization is not clinically advisable
- Who are immunocompromised, at significant risk from UTI, interstitial cystitis, or pyleonephritis, or who have severely compromised urinary mucosa
- Unable to tolerate antibiotic therapy
- On anticoagulants
- With overflow incontinence or neurogenic bladder

If requested, the medical record must contain information that substantiates the need for this item.

This coverage expansion will be incorporated into the next revision of the Urological Supplies LCD.

Refer to the Urological supplies LCD and Policy Article for additional information.

Registration Now Open - 2010 DME MAC Jurisdiction A Symposiums (GEN)

Registration is now open for the first DME MAC Jurisdiction A Educational Symposium additional locations will be opening shortly. Registration will be taken on a first come, first served basis until maximum capacity has been reached for each location. We are excited to be offering a dynamic range of topics and speakers. Attendees will have the opportunity to interact directly with these various Medicare Contractors as well as State and National DMEPOS Associations in order to enhance their educational experience and get the most out of this excellent opportunity.

A Symposium Web page is available on the DME MAC A Web site, which can be accessed at:
http://www.medicarenhic.com/dme/symposium/Symposium_General_Information.shtml

This web page contains details and registration information. ListServe messages will be issued each time this page is updated. NHIC, Corp. DME MAC Jurisdiction A would like to extend this invitation to all interested Jurisdiction A suppliers.

Please forward this information to all applicable individuals and keep watching for more details!

We look forward to seeing you there!

Medigap Claim-based Crossover Instructions for the New NCPDP Format Version D.0 (GEN)

Retail pharmacies billing claims to Medicare in the current NCPDP (National Council for Prescription Drug Programs) format version 5.1 that would like to trigger claim-based crossover to Medigap when beginning the use of the new NCPDP format version D.0 should continue to enter the Medigap claim-based COBA ID (range 55000 to 59999) in the existing 301-C1 (Group ID) portion of the Transmission Insurance Segment. This is not a change from the NCPDP format version 5.1; however, there is a change to where you will report the beneficiary's Medigap policy number in the new NCPDP format version D.O. You should report the Medigap policy number in the new 359-2A (Medigap ID) portion of the new version as opposed to the 330-CW (Alternate ID) portion of the Transmission Claim Segment that is used currently.

For example:

NCPDP Version	COBA ID (Same)	Medigap Policy Number (Different)
Current - NCPDP 5.1	301-C1 (Group ID)	330-CW (Alternate ID)
New - NCPDP D.O.	301-C1 (Group ID)	359-2A (Medigap ID)

When any of the required information is missing or incomplete, no transfer of claim information will occur. It is recommended that you confirm that the COBA IDs are correct by accessing the CMS Web site at **http://www.cms.gov/COBAgreement**. Scroll toward the bottom of the page to the "**Downloads Section**" where you can access a PDF document entitled "**Medigap Claim-based COBA IDs for Billing Purpose**".

Attention DMEPOS Providers - Help DME MAC A Promote PECOS Enrollment (GEN)

The Centers for Medicare and Medicaid Services (CMS) recently began an outreach initiative with the Medicare A/B MAC Contractors to help promote PECOS enrollment. As a result, we would like join in on this initiative and we need you, our DMEPOS suppliers, to assist with these efforts.

Effective June 28, 2010, all physicians and non-physician practitioners currently enrolled in Medicare but who did not have enrollment records in the Provider Enrollment, Chain and Ownership System (PECOS) should have begun receiving targeted outreach letters from their A/B MAC Contractor. These letters were designed to highlight the key reasons why it is imperative for action to occur and also requests that immediate steps be taken to do so.

In order for these efforts to move in a positive direction and be successful to all that are impacted by PECOS enrollment, we need you to share the below information with your ordering/referring practitioners. The end result will significantly impact your business and bottom line.

- CMS Informational Article (MM6842) **http://www.cms.gov/MLNMattersArticles/downloads/MM6842.pdf**
- Copy of Targeted Outreach Letter (CR6842) **http://www.medicarenhic.com/dme/articles/070210_pecos.pdf**
- CMS PECOS Webpage **http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp**
- DME MAC A PECOS Webpage **http://www.medicarenhic.com/dme/dme_pecos.shtml**

Thank you, in advance, for taking part in making PECOS enrollment a success.

New Interactive Remittance Advice (RA) added to DME MAC A Web site (GEN)

The DME MAC A Outreach & Education Team has created a comprehensive *Interactive Remittance Advice* (RA) located on our web site at: **http://www.medicarenhic.com/dme/dme-eduonline.shtml#gandif**. This form will provide detailed information regarding each field located within the RA along with references. To navigate through this form, simply click on a section within the RA and an explanation will be provided for each field.

For additional information on the RA refer to *Understanding the Remittance Advice (RA) A Guide for Medicare Providers, Physicians, Suppliers and Billers 2nd Edition* located at: **http://www.cms.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf**

Second Quarter 2010 - Top Claim Submission Errors (GEN)

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

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

Top Ten Claims Submission Errors	*Number Received*	*Reason For Error*
C172 - Invalid Procedure Code and/or Modifier	219,238	The procedure code, modifier, or procedure code and modifier combination is invalid.
C095 - Diagnosis Code Invalid - Pointer 1	47,773	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.

Top Ten Claims Submission Errors	*Number Received*	*Reason For Error*
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	43,804	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).
C044 - Subscriber Primary ID Invalid	42,486	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C003 - Billing NPI Not Found on Crosswalk	39,519	There is no link between the NPI that was submitted and a PTAN/NSC.
C171 - Capped Rental - Modifier Missing	34,959	The item (whether for purchase or rental) is classified as a capped rental item (or possibly a pen pump item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.
C143 - Ordering Provider ID Qualifier Invalid	31,681	The Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line.
B108 - Billing provider not authorized for submitter	27,922	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C180 - Service Date Greater than Receipt Date	20,659	The service start/from date is greater than the date this claim was received.
C179 - Service From/To Dates Not Equal	20,041	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.

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

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

Claims Submission Errors (Return/Reject Denials)	**CMS 1500 Form (or electronic equivalent) Entry Requirement**	**Number Received**
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	48,234
CO 182 N56 Procedure modifier was invalid on the date of service.	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	11,976
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.	2,959
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.	2,486
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	2,069

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
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.	1,069
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.	805
CO 16 N257 Missing / incomplete / invalid billing provider/supplier primary identifier.	**Item 33** - Provider Transaction Access Number (PTAN) number submitted in error. Must submit National Provider Identifier (NPI).	789
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.	745
CO 129, MA130 Prior processing information appears incorrect. Your claim contains incomplete and/or invalid information.	**Loops 2320 or 2430 (EMC)** - The claim line has two or more segments containing Claim Adjustment Reason Codes (CARC) . This is an Medicare Secondary Payer (MSP) error.	741

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.

Quarterly Provider Update (GEN)

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at **http://www.cms.gov/QuarterlyProviderUpdates/**. CMS encourages you to bookmark this Web site and visit it often for this valuable information.

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 August of 2010 chapters 2, 4, 5 and 10 of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

DME MAC A ListServes (GEN)

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

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

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

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 Jurisdiction A DME MAC will continue to offer our quarterly bulletin, the *DME MAC Jurisdiction A Resource*, in electronic format via our Web site, where copies can be printed free of charge. To access the bulletin, go to the "Publications" section of our Web site at: ***http://www.medicarenhic.com/dme/dme_publications.shtml***. To be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, subscribe to the DME MAC A ListServe, our electronic mailing lists by visiting: ***http://www.medicarenhic.com/dme/listserve.html***

For Suppliers without Internet Access: If you do not have Internet access and require the bulletin via hardcopy or CD-ROM*, you may subscribe to it for a fee. The annual subscription fee is $65.00 for hardcopy and $172.00 for CD-ROM. ***This subscription includes the four quarterly bulletins published during the calendar year of (2011) - March, June, September and December.*** Complete this form and submit with payment, via check only, to the address listed below.

* The CD-ROM version of the bulletin is a Portable Document Format (PDF) file. To view PDFs, you must have Adobe® Acrobat® Reader® installed on your computer.

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By completing this form and signing below, I certify I do not have access to the Internet, or have some other technical barrier, preventing me from accessing the *DME MAC Jurisdiction A Resource* and therefore request I receive an annual hardcopy subscription. I understand I will have to renew my subscription annually to continue receiving hardcopy of *DME MAC Jurisdiction A Resource*.

Enclose your check payable to: **NHIC, Corp.**

Mail your completed form with payment to: **NHIC, Corp.**
Cash Accounting / DME Subscription
75 Sgt William B Terry Drive
Hingham, MA 02043

Signature: _____ Date: _____

For Your Notes

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**

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

Written Inquiries

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

Written Inquiry FAX: 781-741-3118

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

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

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Redetermination Requests Fax: 781-741-3118

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

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

Faxed Reopenings: 781-741-3914

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:

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

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Mailing Address:

Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:

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

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

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

DME MAC Jurisdiction A Resource

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

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Publication Information

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

Visit the following websites for more information:

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

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

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

DME MAC Jurisdiction A Resource Coordinator
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NHIC, Corp.
75 Sgt. William B. Terry Drive
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