DME MAC Jurisdiction A Resource

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

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December 2011
Number 22

General Information

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

2011-2012 Seasonal Influenza (Flu) Resources for Health Care Professionals (SE1136) (GEN)

MLN Matters® Number: SE1136
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This article is for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

What You Need to Know
- Keep this Special Edition Medicare Learning Network (MLN) Matters article and refer to it throughout the 2011 - 2012 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction
Flu seasons are unpredictable and can be severe. Over a period of 30 years, between 1976 and 2006, estimates of flu-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people (**Flu.gov**. 2011. About the Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2011 [cited 16 September 2011]. Available from the World Wide Web: **http://www.flu.gov/individualfamily/about/index.html**). Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) Medicare provides coverage of the seasonal influenza virus vaccine and its administration for all Medicare beneficiaries regardless of risk for the disease; however, some individuals are at greater risk for contracting influenza. Vaccination is recommended for all individuals aged 6 months and older. While everyone should get a seasonal influenza vaccine each influenza season, it's especially important that certain groups get vaccinated either because they are at high risk of having serious influenza-related complications or because they live with or care for people at high risk for developing influenza-related complications. For more information, refer to the most recent recommendations at **http://www.cdc.gov/flu/protect/keyfacts.htm** on the Centers for Disease Control (CDC) website.

Vaccinate Early to Protect Against the Flu
The CDC recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff.

Get the Flu Vaccination - Not the Flu.
Remember - The influenza vaccine plus its administration are covered Part B benefits. Note that the influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit **http://www.cms.gov/MLNProducts/35_PreventiveServices.asp** on the CMS website.

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

MLN Seasonal Influenza Related Products for Health Care Professionals

- ***MLN Matters ® Article MM7575: Influenza Vaccine Payment Allowances - Annual Update for 2011-2012 Season*** - This article contains information on the payment allowances for influenza vaccines for the 2011-2012 season. You can view this article at **http://www.cms.gov/MLNMattersArticles/Downloads/MM7575.pdf** on the CMS website.

- ***Quick Reference Information: Medicare Part B Immunization Billing*** - This educational tool is designed to provide education on Medicare-covered preventive immunizations. Available in print and as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf** on the CMS website. This product is also available in hardcopy as part of the "Quick Reference Information Resources" hardcopy booklet.

- ***The Guide to Medicare Preventive Services, Fourth Edition*** - This guide is designed to provide education on Medicare's preventive benefits. Available as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the CMS website.

- ***Preventive Immunizations Brochure*** - This brochure is designed to provide education on Medicare's Influenza Vaccine, Pneumococcal Vaccine, and Hepatitis B Vaccine benefits. Available in print and as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/Adult_Immunization.pdf** on the CMS website.

- ***Quick Reference Information: Preventive Services*** - This educational tool is designed to provide education on the Medicare-covered preventive services. Available as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf** on the CMS website. This product is also available in hardcopy as part of the "Quick Reference Information Resources" hardcopy booklet.

- ***Quick Reference Information Resources: Medicare Preventive Services*** - This booklet is designed to provide education on coverage, coding and billing criteria for Medicare-covered preventive services. It includes the following four quick reference information charts: Preventive Services, Medicare Immunization Billing, The ABCs of Providing the Initial Preventive Physical Examination and The ABCs of Providing the Annual Wellness Visit. Available in hardcopy only.

Note: To order hardcopy products, please visit the MLN Preventive Services Educational Products web page at **https://www.cms.gov/MLNProducts/35_PreventiveServices.asp** and select "MLN Product Ordering Page" in the "Related Links Inside CMS" section.

- ***MLN Preventive Services Educational Products Web Page*** - This Medicare Learning Network® (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. View this page at **http://www.cms.gov/MLNProducts/35_PreventiveServices.asp** on the Internet.

Other CMS Resources

- **Seasonal Influenza Vaccines Pricing** is at **http://www.cms.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp** on the Internet.

- **Prevention General Information Overview** is at **http://www.cms.gov/PrevntionGenInfo** on the Internet.

- **CMS Immunizations page** is at **http://www.cms.gov/immunizations** on the CMS website.

- **CMS Frequently Asked Questions** are available at **http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi** on the CMS website.

- ***Medicare Benefit Policy Manual*** **- Chapter 15, Section 50.4.4.2 - Immunizations** available at **http://www.cms.gov/manuals/downloads/bp102c15.pdf** on the CMS website.

- *Medicare Claims Processing Manual* - **Chapter 18, Preventive and Screening Services** available at **http://www.cms.gov/manuals/downloads/clm104c18.pdf** on the CMS website.

- **Medicare Part B Drug Average Sales Price Payment Amounts**
  Influenza and Pneumococcal Vaccines Pricing found at
  http://www.cms.gov/McrPartBDrugAvgSalesPrice/01_overview.asp on the Internet.

- **2011-2012 Immunizers' Question & Answer Guide to Medicare Part B and Medicaid Coverage of Seasonal Influenza and Pneumococcal Vaccinations** available at
  http://www.cms.gov/Immunizations/Downloads/20112012ImmunizersGuide.pdf on the CMS website.

- **Immunizations Web Page** at
  http://www.cms.gov/immunizations on the CMS website.

Other Resources
The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2011 - 2012 flu season:

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

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

Additional Fields for Additional Documentation Request (ADR) Letters (MM7254) (GEN)

MLN Matters® Number: MM7254 Revised
Related CR Release Date: September 15, 2011

Related CR Transmittal #: R958OTN

Related Change Request (CR) #: 7254
Effective Date: January 1, 2012, except April 1, 2012 for suppliers billing DME MACs
Implementation Date: January 3, 2012, except April 2, 2012 for DME MACs

Note: *This article was revised on September 30, 2011, to clarify the description of the content in the ADR. All other information remains the same.*

Provider Types Affected
This article is for physicians, providers, and suppliers who must respond to ADRs from Medicare Administrative Contractors (A/B MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

What You Need to Know
CR 7254, from which this article is taken, makes changes to the Medicare systems that allow A/B MACs and DME MACs to include, on Additional Documentation Request (ADR) letters, information about the Electronic Submission of Medical Documentation (esMD) pilot.

Background
CR7254, from which this article is taken, announces several changes to the Medicare systems that enable Medicare Review Contractors, participating in the esMD pilot, to include on ADR letters additional information necessary for Electronic Submission of Medical Documentation (esMD).

Specifically, these will allow MACs to include in each ADR:

- A statement about how providers can get more information about submitting medical documentation via the esMD mechanism
- A documentation case ID number that may facilitate tracking of submitted documents.

Additional Information
You can find the official instruction, CR7254, issued to your A/B MAC or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R958OTN.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

You can learn more about the esMD pilot by going to **http://www.cms.gov/ESMD/** on the CMS website. In addition, MLN Matters® article SE1110 provides more details on the esMD initiative. That article is at **http://www.cms.gov/MLNMattersArticles/downloads/SE1110.pdf** on the CMS website.

If you have any questions, please contact your 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.

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement (MM7599) (GEN)

MLN Matters® Number: MM7599
Related CR Release Date: October 7, 2011
Related CR Transmittal #: R2317CP

Related Change Request (CR) #: 7599
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME 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 are affected.

Provider Action Needed
This article announces that Change Request (CR) 7599 is a recurring update notification that provides the annual HH consolidated billing update, effective January 1, 2012. Make sure your billing staff is aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the HH Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for

whom such a service is being billed is in a HH episode (i.e., under a HH plan of care administered by a home health agency). Medicare will only directly reimburse the primary HH agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. New updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key Points
The HCPCS codes in the table below are being added to the HH consolidated billing supply code list.

Added HCPCS Code	Descriptor
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each.
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each.

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

The official instruction (CR7599) issued to your Medicare Carrier/FI/RHHI/MAC is available at **http://www.cms.gov/Transmittals/downloads/R2317CP.pdf** on the CMS website on the CMS website.

Billing for Donor Post-Kidney Transplant Complication Services (MM7523) (GEN)

MLN Matters® Number: MM7523 Revised
Related CR Release Date: October 28, 2011

Related CR Transmittal #: R148BP and R2334CP

Related Change Request (CR) #: 7523
Effective Date: April 1, 2012 for claims processing, but policy effective November 28, 2011
Implementation Date: April 2, 2012

Note: *This article was revised on November 7, 2011, to include sample claims as examples at the end of the article. All other information is the same.*

Provider Types Affected
Providers submitting claims to Medicare contractors (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.

What You Need to Know
Change Request (CR) 7523 does not convey any new or changed policy, but does convey clarification language for two Medicare manuals. This clarification is being provided to ensure consistency among all Medicare contractors in processing claims for Donor Post-Kidney Transplant Complications services. Be sure your staff is aware of the clarifications.

Key Points of CR7523
Section 140.9 of Chapter 11 of the "*Medicare Benefit Policy Manual*" is being updated to show the following:

The donor of an organ for a Medicare transplant is covered for an unlimited number of days of care in connection with the organ removal operation. Days of inpatient hospital care used by the donor in connection with the organ removal operation shall not be charged against either party's utilization record.

Regarding donor follow-up:

- Expenses incurred by the transplant center for routine donor follow-up care are included in the transplant center's organ acquisition cost center.
- Follow-up services performed by the operating physician are included in the 90-day global payment for the surgery. Beyond the 90-day global payment period, follow-up services are billed using the recipient's health insurance claim number.
- Follow-up services billed by a physician other than the operating physician for up to 3 months should be billed under the recipient's health insurance claim number.

Regarding donor complications:

- Expenses incurred for complications that arise with respect to the donor are covered only if they are directly attributable to the donation surgery. Complications that arise after the date of the donor's discharge will be billed under the recipient's health insurance claim number. This is true of both facility cost and physician services. Billings for donor complications will be reviewed.
- In all of these situations, the donor is not responsible for co-insurance or deductible.

In addition, CR7523 is adding language to Section 90.1.3 of Chapter 3 of the "*Medicare Claims Processing Manual*" to provide clarifications as follows:

- Expenses incurred for complications that arise with respect to the donor are covered and separately billable only if they are directly attributable to the donation surgery.
- All covered services (both institutional and professional) for complications from a Medicare covered transplant that arise after the date of the donor's transplant discharge will be billed under the recipient's health insurance claim number and are billed to the Medicare program in the same manner as all Medicare Part B services are billed.
- All covered donor post-kidney transplant complication services must be billed to the account of the recipient (i.e., the recipient's Medicare number).
- Modifier Q3 (Live Kidney Donor and Related Services) appears on each covered line of the claim.
- Institutional claims will be required to also include:
  - Occurrence Code 36 (Date of Inpatient Hospital Discharge for covered transplant patients); and
  - Patient Relationship Code 39 (Organ Donor).

Sample claims appear at the end of this article to provide examples of the above coding instructions.

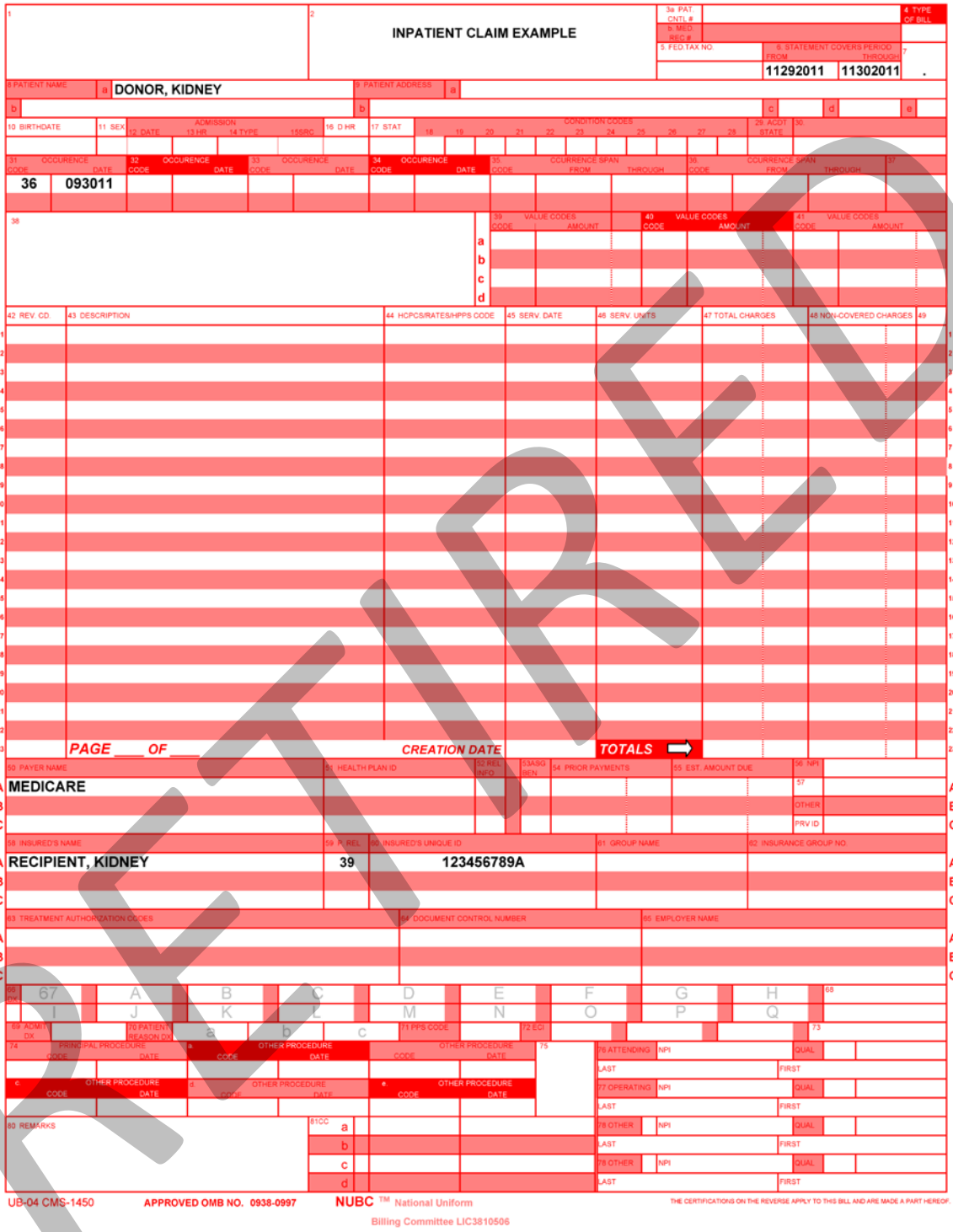
Additional Information

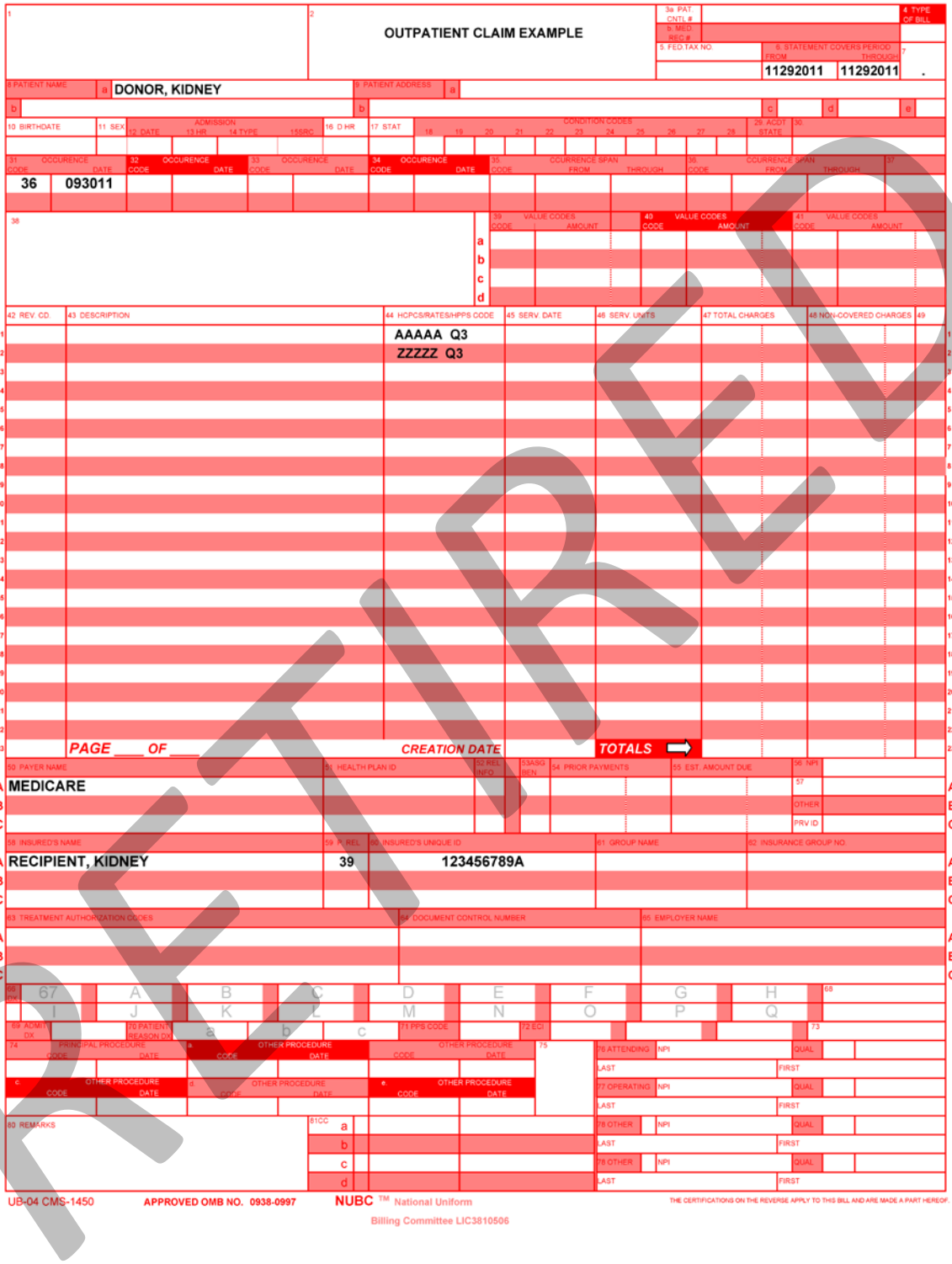
The official instruction, CR7523, was issued to your RHHI, FI or A/B MAC via two transmittals. The first modifies the "*Medicare Benefit Policy Manual*" and it is at **http://www.cms.gov/Transmittals/downloads/R148BP.pdf** and the second at **http://www.cms.gov/Transmittals/downloads/R2334CP.pdf** modifies the "*Medicare Claims Processing Manual*".

If you have any questions, please contact your RHHI, 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.

Provider Services Portal (PSP)

NHIC, Corp. has been receiving requests to have a program that DME MAC Jurisdiction A suppliers can use to easily access beneficiary eligibility and claims information over the internet. The PSP is now available for open enrollment! If you are interested in becoming a PSP participant visit:
http://www.medicarenhic.com/dme/dme_psphome_index.shtml


INPATIENT CLAIM EXAMPLE
DONOR, KIDNEY
11292011
11302011
36
093011
PAGE ___ OF ___
CREATION DATE
TOTALS
MEDICARE
RECIPIENT, KIDNEY
39
123456789A
UB-04 CMS-1450
APPROVED OMB NO. 0938-0997
NUBC ™ National Uniform
Billing Committee LIC3810506



OUTPATIENT CLAIM EXAMPLE

6 STATEMENT COVERS PERIOD: FROM 11292011 THROUGH 11292011

8 PATIENT NAME: a DONOR, KIDNEY

31 OCCURENCE CODE 36 DATE 093011

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS/RATES/HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES

1 AAAAA Q3

2 ZZZZZ Q3

PAGE ___ OF ___ CREATION DATE TOTALS

50 PAYER NAME: A MEDICARE

58 INSURED'S NAME: A RECIPIENT, KIDNEY

59 P REL: 39

60 INSURED'S UNIQUE ID: 123456789A

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC ™ National Uniform Billing Committee LIC3810506

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) and PC Print Update (MM7514) (GEN)

MLN Matters® Number: MM7514
Related CR Release Date: September 15, 2011
Related CR Transmittal #: R2304CP

Related Change Request (CR) #: 7514
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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

Provider Action Needed
Change Request (CR) 7514, from which this article is taken, announces the latest update of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARCs) that are effective on October 1, 2011, for Medicare. It also instructs certain Medicare contractors to update Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs 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. A national code maintenance committee maintains the Healthcare Claim Adjustment Reason Codes (CARCs). The CARC list is updated three times a year in early March, July, and November. The Centers for Medicare & Medicaid Services (CMS) maintains the Remittance Advice Remark Code (RARC) list, which is used by all payers. The RARC list is also updated three times a year in early March, July, and November.

Both code lists are posted on the Washington Publishing Company (WPC) website, available at **http://www.wpc-edi.com/Codes** on the Internet.

The lists at the end of this article summarize the latest changes to these code lists, as announced in CR7514.

Additional Information
If you use the MREP and/or PC Print software, be sure to obtain an updated copy once it is available.

The official instruction, CR7514, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R2304CP.pdf** on the 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.

CR 7514 Changes

New Codes - CARC

Code	Current Narrative	Effective Date
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	6/5/2011

Modified Codes - CARC
None

Deactivated Codes - CARC
None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected, this will not be paid in the future.	Yes
N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.	Yes
N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.	Yes

Modified Codes - RARC:
None

Deactivated Codes - RARC:
None

Claim Status Category and Claim Status Codes Update (MM7585) (GEN)

MLN Matters® Number: MM7585
Related CR Release Date: September 30, 2011
Related CR Transmittal #: R2314CP
Related Change Request (CR) #: 7585
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

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

Provider Action Needed
This article, based on Change Request (CR) 7585, explains that the Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the Committee meeting. These meetings are held in the January/February time frame, again in June and finally in late September or early October, in conjunction with the Accredited Standards Committee (ASC) X12 meetings.

The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. Medicare contractors will begin using the current codes posted at **http://www.wpc-edi.com/codes** on the Internet, on or about November 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All providers are reminded to ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

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

Additional Information
The official instruction, CR7585, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R2314CP.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.

Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities (SE1123) (GEN)

MLN Matters® Number: SE1123
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
All physicians, providers, and suppliers who submit claims to Medicare contractors (as defined in this article) for services and supplies provided to Medicare beneficiaries are affected.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) has received calls from providers about the various entities that may contact them with questions and requests for medical records, documentation, or other information. CMS recognizes that shifts in contracting entities due to recent Medicare Contracting Reform may be confusing. CMS has prepared this Special Edition article to describe the current Medicare contracting environment. In addition, this article will list the entities responsible for activities in the Medicare Program, as well as with some Medicaid claims, and explain the reasons why they may contact you. CMS has also prepared a quick reference table titled, "Contractor Entities at a Glance: Who May Contact You about Specific Centers for Medicare & Medicaid Services (CMS) Activities," that you may provide to your office staff for easy reference. The table is available at **http://www.cms.gov/MLNProducts/downloads/ContractorEntityGuide_ICN906983.pdf** on the CMS website.

CMS understands that several of these entities may contact you concurrently. You may question whether the efforts of these entities are coordinated and whether the burden placed upon providers can be reduced. CMS constantly strives to reduce the burden on providers. However, as this article explains, certain functions are performed by different entities by design. Sometimes different entities are involved because different skill sets are needed. For example, reviewing a provider enrollment application for correctness requires different skills than reviewing medical records to determine correct diagnosis and procedure coding. Also, sometimes certain functions must be performed by different entities to protect providers and the Medicare Program. For example, appeals of claims decisions should be heard, at least at certain levels, by an entity that is separate and distinct from the entity that made the claims decision. Therefore, while CMS strives to coordinate efforts of these entities, there may be times when providers are contacted by several of the entities concurrently.

Background
Listed below are general categories of the current entities that CMS uses under the Medicare and Medicaid programs to handle claims processing and other functions. Some of the entities are new to these programs as part of Medicare Contracting Reform. This article and the table mentioned above display the new entities in **bold type**. The table also provides websites that are available should you need further information. Finally, we explain how CMS coordinates the work of these entities so that phone calls and letters requesting medical records, documentation, or other information related to a beneficiary's claims are minimized.

Claims Processing Contractors
CMS contracts with entities to process claims submitted by physicians, hospitals, and other health care providers/suppliers, and to make payment in accordance with Medicare regulations and policies. These entities, called carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), **and Medicare Administrative Contractors (MACs)**, are also referred to as Medicare claims processing contractors. These entities are the entry point for participating in the Medicare program as they process provider enrollment applications.

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) mandated that the Secretary of the Department of Health and Human Services (DHHS) replace the current contracting authority under Title XVIII of the *Social Security Act* (SSA) with the new **MAC** authority.

MACs will be the central point in CMS' national Fee-For-Service (FFS) program.

- Carrier and FI workloads have or will be transitioned to **10 Part A/ B MAC** jurisdictions.
- Regional Home Health Intermediary (RHHI) workloads are being transitioned to **4 HH MAC** jurisdictions.

- Durable Medical Equipment (DME) workloads have been transitioned to **4 DME MAC jurisdictions**.

You may access the most current Medicare Contracting Reform information to determine the effect of these changes on your practice and to view the list of current **MACs** for each jurisdiction at **http://www.cms.gov/MedicareContractingReform** on the CMS website.

MACs may contact you for a variety of reasons, such as:

- Resolving issues regarding your initial and renewal enrollment applications;
- Providing education and guidance on procedures for billing Medicare;
- Resolving issues regarding claims you submit;
- Requesting medical records related to the claims you submit for medical review;
- Paying you for approved claims and/or explaining why some claims are not processed or are denied; and
- Recovering overpayments on claims previously processed.

Program Integrity Contractors

CMS contracts with Program Safeguard Contractors (PSCs) and **Zone Program Integrity Contractors (ZPICs)**, who are responsible for identifying cases of suspected fraud and taking appropriate actions. As a result of Medicare Contracting Reform, seven ZPICs were created based on the MAC jurisdictions. Eventually, PSCs will no longer exist and ZPICs will perform all benefit integrity work. ZPICs were created to perform program integrity for Medicare Parts A, B, C (Medicare Advantage or MA), D (Prescription Drugs, including MA-Drug Plans), Durable Medical Equipment (DME), Home Health and Hospice, and Medicare-Medicaid data matches, also referred to as Medi-Medi. Since these seven **ZPICs** focus on these different aspects of the Medicare Program, it is possible that providers could hear from more than one **ZPIC**, depending on the aspects of that **ZPIC's** review and/or the nature of the services for which the provider bills Medicare.

CMS also contracts with **Recovery Auditors** to identify and correct underpayments and overpayments. There are 4 **Recovery Auditors**. **Recovery Auditors** responsibilities include working with providers to detect and correct Medicare improper payments. **Recovery Auditors** conduct reviews of claims in the following ways:

- Automated (no medical records are needed);
- Semi-Automated (medical records are supplied at the discretion of the provider to support a claim identified by data analysis as an improper payment); and
- Complex (medical record is required).

FFS Recovery Auditors contact providers to request additional documentation in support of potential improper payments. If an improper payment is determined, the **FFS Recovery Auditor** will send a review results letter, providing the decision and the accompanying reviewer rationale. A Demand letter is issued to you by the **FFS Recovery Auditor** or the MAC once the claim is adjusted. The **FFS Recovery Auditor** will offer you an opportunity to discuss the improper payment determination with the **FFS Recovery Auditor** (this is outside the normal appeal process).

The **Tax Relief and Health Care Act of 2006 (TRHCA)** authorizes the **Recovery Audit** program for Part A and Part B Medicare services.

The **Affordable Care Act** expands the **Recovery Audit** program to Medicaid and Medicare Part C (Medicare Advantage or MA) and Part D (prescription drugs).

- Medicaid Recovery Auditors are responsible for identifying and recovering Medicaid overpayments and identifying underpayments.
- MA Recovery Auditors will ensure that MA plans have an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.
- Prescription Drug Plan (PDP) Recovery Auditors will ensure that each PDP under part D has an anti-fraud plan in effect and review the effectiveness of each anti-fraud plan.

CMS also reviews Medicare FFS claims nationally to identify improper payments, as required by the *Improper Payment Information Act* (IPIA) and the *Improper Payments Elimination and Recovery Act* (IPERA). This is accomplished through the **Comprehensive Error Rate Testing (CERT) program**. If a provider's claim is randomly chosen, the CERT program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly. If an improper payment is identified by the CERT program, your MAC will notify you and make the appropriate payment adjustment. Normal appeal rights apply to CERT-initiated denials and are handled through the routine appeal process.

CMS also reviews Medicaid and Children's Health Insurance Program (CHIP) claims to identify improper payments, as required by the IPIA and the IPERA. This is accomplished through the **Payment Error Rate Measurement (PERM) program**.

CMS reviews a sample of claims in one-third of the states each year to develop a national estimate of improper payments. PERM conducts two types of reviews on these claims:

- Medical review (medical record is required)
- Data processing reviews (this is a validation that the payment was processed correctly in a state's system)

If a provider's claim is randomly chosen, the PERM program will contact the provider to obtain medical records that support the claim and will conduct a review of the medical records to determine if the claim was paid correctly.

Medicaid Integrity Contractors (MICs) are entities that contract with CMS to conduct audit-related activities for the Medicaid programs. There will be five MIC jurisdictions performing three primary functions:

- Review MICs, which analyze Medicaid claims data to investigate suspected/potential provider fraud, waste, or abuse;
- Audit MICs, which audit provider claims and identify overpayments; and
- Education MICs, which provide education to providers and others on payment integrity and quality-of-care issues.

Program Integrity contractors may contact you to resolve problems they identify in your claims or to request medical records for claims under review.

Specialty Medical Review Contractors

In an effort to continue the prevention and reduction of improper payments, CMS has contracted with a Specialty Medical Review Contractor to conduct medical review studies of Part A and B claims. Studies are conducted as fact-finding undertakings to allow CMS to better understand trends in billing behavior that may lead to improper payments. These studies occur on a quarterly basis and vary in topic. Claims chosen for review are selected randomly.

The Specialty Medical Review Contractor may contact you to request medical records for claims under review.

Also, CMS contracts with the Medicare Coordination of Benefits Contractor (COBC), a single entity, to provide a centralized COB operation. Responsibilities of the COBC include all activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries. The COBC may contact you to identify Medicare Secondary Payer (MSP) situations quickly and accurately.

There is also a Medicare Secondary Payer Recovery Contractor (MSPRC) that performs post-payment recovery of funds paid where Medicare should not have been the primary payer. The MSPRC may contact you for information related to MSP recoveries and can issue demand letters to require payment recovery.

The last specialty contractor is the National Supplier Clearinghouse (NSC), which handles enrollment activities related to Durable Medical Equipment suppliers. The NSC may contact you about your enrollment information.

Appeals Contractors and Entities

CMS contracts with entities to conduct appeals of claims determinations. These include FIs, carriers, RHHIs, and **MACs, who conduct first level appeals**. **Qualified Independent Contractors (QICs)** conduct reconsiderations, the second level of appeals. There are:

- Two Part A **QICs**,
- Two Part B **QICs**,
- One DME **QIC**,
- One Part C **QIC** for MA, and
- One Part D **QIC** for Medicare Prescriptions Drug Plans (PDPs) and MA Drug Plans.

Other appeals-related entities include the Administrative Law Judges (ALJs) within the HHS Office of Medicare Hearings and Appeals and the Medicare Appeals Council within the HHS Departmental Appeals Board conduct the next two levels of appeal. The ALJ will send you a notice of hearing to all parties to the appeal, indicating the time and place of the hearing. The ALJ will generally issue a decision or dismissal within 90 days of receipt of a valid appeal request. The Medicare Appeals Council will generally issue a decision or dismissal within 90 days of receipt of a valid appeals request.

ALJs in the Civil Remedies Division within the HHS Departmental Appeals Board also conduct hearings on provider and supplier enrollment issues, and hearings on civil money penalties and sanctions imposed against providers and suppliers by CMS and the HHS Office of the Inspector General. For appeals of enrollment issues, the ALJ will generally issue a decision within 180 days of receipt of your request. For other types of appeals, the ALJ will issue a decision as soon as practical after the close of the hearing.

The Provider Reimbursement Review Board (PRRB) is an independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination of its fiscal intermediary or the Centers for Medicare & Medicaid Services (CMS). The Medicare Geographic Classification Review Board (MGCRB) decides on requests of Prospective Payment System (PPS) hospitals for reclassification to another area (Urban or in some cases Rural) for the purposes of receiving a higher wage index.

The PRRB and the MGCRB provide appeals avenues for providers on specific matters, including cost report disputes.

When you, or a beneficiary (or an appointed representative), appeal claims decisions, any of these appeals entities may request more information from you (or your representative).

Quality Improvement Contractors

Quality Improvement Organizations (QIOs) provide quality of care review services and conduct quality improvement projects. CMS contracts with one QIO in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. QIOs are private, mostly not-for-profit organizations, staffed by professionals, mostly doctors and other health care professionals, responsible for the review of services provided to beneficiaries enrolled in MA plans and in FFS Medicare, including:

- Conducting expedited Medicare coverage determinations of inpatient hospital discharges and provider service terminations;
- Reviewing beneficiary complaints about quality of care, including working with the provider and reviewing medical records as part of the complaint-resolution process;
- Working with providers to accomplish national quality improvement goals;
- Implementing improvements in the quality of care;
- Contacting providers to provide technical assistance and encouraging partnerships to achieve quality goals;
- Providing technical assistance with many of the CMS Value-Based Purchasing Programs; and
- Performing provider-requested higher-weighted Diagnosis Related Group reviews.

Additional Information

If you have any questions, please contact your Medicare contractor (FI, carrier, RHHI, 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.

CY 2012 Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) (MM7635) (GEN)

MLN Matters® Number: MM7635
Related CR Release Date: November 4, 2011
Related CR Transmittal #: R2340CP

Related Change Request (CR) #: CR 7635
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

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

Impact to You

Updates and information in CR 7635 can impact reimbursement for your claims for DMEPOS items or services.

What You Need to Know
This article, based on Change Request (CR) 7635, advises you of the Calendar Year (CY) 2012 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2012.

What You Need to Do
You should make that sure your billing staffs are aware of these changes.

Background and Key Points of CR 7635
Payment on a fee schedule basis is required for durable medical equipment, prosthetic devices, orthotics, prosthetics, and surgical dressings (DMEPOS) by Sections 1834(a), (h), and (i) of the *Social Security Act* (the Act); and for parenteral and enteral nutrition (PEN) by 42 CFR, Section 414.102.

In accordance with these statutes and regulations, the DMEPOS fee schedules are updated annually; and the process for this update is documented in the "*Medicare Claims Processing Manual*", Chapter 23 Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule at **http://www.cms.gov/manuals/downloads/clm104c23.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

CR 7635, from which this article is taken, provides instructions regarding annual the DMEPOS fee schedule annual update for 2012.

Fee Schedule Files
The DMEPOS fee schedule file will be available on or after November 16, 2011, for State Medicaid Agencies, managed care organizations, and other interested parties at **http://www.cms.hhs.gov/DMEPOSFeeSched/** on the CMS website.

HCPCS Codes Added
The following new codes are effective as of January 1, 2012:

- A9272 which has no assigned payment category;
- A5056 and A5057 in the ostomy, tracheostomy, and urological supplies (OS) payment category;
- E0988 in the capped rental (CR) category;
- L5312, L6715, and L6880 in the prosthetics and orthotics category; and
- E2358, E2359, E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 in the inexpensive/routinely purchased (DME) payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2012 DMEPOS Fee Schedule Update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2012 through June 30, 2012. The new codes are not to be used for billing purposes until they are effective on January 1, 2012.

Please note that the HCPCS codes listed as new codes in this CR may not be final and are subject to change pending release of the CY 2012 HCPCS file.

For gap-filling purposes, the 2011 deflation factors by payment category are listed in the following table:

Factor	Category
0.485	Oxygen
0.488	Capped Rental
0.490	Prosthetics and Orthotics
0.621	Surgical Dressings
0.676	Parenteral and Enteral Nutrition

HCPCS Codes Deleted
The following codes are being deleted from the HCPCS effective January 1, 2012, and are therefore being removed from the DMEPOS fee schedule files:

- E0571
- L1500, L1510, L1520, L3964, L3965, L3966, L3968, L3969, L3970, L3972, L3974, L4380, L5311, L7266, L7272, L7274, and L7500.

Specific Coding and Pricing Issues

CMS has learned that the current language in the "*Medicare Claims Processing Manual*", Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60.3(Gap-filling DMEPOS Fees), that describes the longstanding methodology for calculating gap-filled fee schedule amounts, can be misinterpreted.

For this reason, CR 7635 revises the first paragraph of this section by replacing the phrase "previous data base period" with "fee schedule data base year," and later in the same sentence replacing the phrase "database year" with "fee schedule database year." These revisions closely approximate the original gap-fill instructions as they appeared in the "*Medicare Carriers Manual*", Part 3 (Claims Process), Section 5102 (Fee Schedules For Durable Medical Equipment and Orthotic/Prosthetic Devices). In addition, CR 7635 revises this section to include the addition of the 2011 deflation factors, as noted above.

CR 7635 also announces other coding and pricing changes, effective January 1, 2012:

1. New HCPCS codes: E2626, E2627, E26268, E 2629, E2630, E2631, E2632, and E2633 (for wheelchair accessories for shoulder elbow arm supports) are re-designated from codes L3964-L3974 and the fee schedule amounts will be directly assigned from the deleted codes to the new codes.
2. The fee schedule amounts for shoe modification HCPCS codes A5503 through A5507 are being adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the original fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2012, the base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2010 and the fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change.

KE Modifier Update

To ensure appropriate modifier processing when submitting claims for HCPCS code E0776 (IV Pole), suppliers should bill using the following modifiers depending upon the type of pump that the IV pole is used with:

- For use with infusion pumps - submit E0776RR, E0776NU, or E0776UE;
- For use with parenteral pumps - submit E0776RRBAKE, E0776NUBAKE, or E0776UEBAKE;
- For use with enteral pumps - submit E0776RRBA, E0776NUBA or E0776UEBA; or
- For use with enteral pumps by beneficiaries that permanently reside in Round I Rebid competitively bid areas - submit E0776RRBAKG, E0776NUBAKG or E0776UEBAKG.

- Similarly, when submitting claims for a replacement HCPCS code E2373 (POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK) suppliers should bill using the following modifiers depending upon the associated base wheelchair:
  For use with a power wheelchair HCPCS code that was bid in Round I of the DMEPOS Competitive Bidding Program - submit E2373KCRR, E2373KCNU or E2373KCUE;
- For use with a power wheelchair HCPCS code that was not bid in Round I of the DMEPOS Competitive Bidding Program - submit E2373KCRRKE, E2373KCNUKE or E2373KCUEKE; or
- For beneficiaries that permanently reside in Round I Rebid competitively bid areas when used with a power wheelchair HCPCS code that was bid in the Round I Rebid of the DMEPOS Competitive Bidding Program - submit E2373KCRRKK, E2373KCNUKK or E2373KCUEKK.

Note: *The above billing instructions supersede the E0776 and E2373 KC billing instructions furnished in Transmittal 1630, CR6270, dated November 7, 2008.*

Attachment B to CR 7635 contains a list of the HCPCS codes that were selected in 2008 for Round I of the DMEPOS Competitive Bidding Program. For beneficiaries who permanently reside in Round I Rebid competitive bid areas, a list of the Round 1 Rebid competitively bid items is available in the single payment amount charts located at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Single%20Payment%20Amounts** on the Competitive Bidding Implementation Contractor (CBIC) website.

CY 2012 Fee Schedule Update Factor
For CY 2012, the update factor of 2.4 percent is applied to the applicable CY 2011 DMEPOS fee schedule amounts.

In accordance with section 1834(a)(14) of the Act, the DMEPOS fee schedule amounts are to be updated for 2012 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2011, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 1.2 percent and the CPI-U percentage increase is 3.6 percent. Thus, the 3.6 percentage increase in the CPI-U is reduced by the 1.2 percentage increase in the MFP resulting in a net increase of 2.4 percent for the MFP-adjusted update factor.

2011 Update to Labor Payment Rates
2012 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 3.6 percent effective for dates of service on or after January 1, 2012 through December 31, 2012, and those rates are as follows:

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
AK	$26.47	$30.16	$35.48		NC	$14.05	$20.94	$28.43
AL	14.05	20.94	28.43		ND	17.51	30.10	35.48
AR	14.05	20.94	28.43		NE	14.05	20.92	39.64
AZ	17.37	20.92	34.98		NH	15.08	20.92	28.43
CA	21.56	34.38	40.07		NJ	18.96	20.92	28.43
CO	14.05	20.94	28.43		NM	14.05	20.94	28.43
CT	23.47	21.41	28.43		NV	22.39	20.92	38.75
DC	14.05	20.92	28.43		NY	25.88	20.94	28.43
DE	25.88	20.92	28.43		OH	14.05	20.92	28.43
FL	14.05	20.94	28.43		OK	14.05	20.94	28.43
GA	14.05	20.94	28.43		OR	14.05	20.92	40.88
HI	17.37	30.16	35.48		PA	15.08	21.54	28.43
IA	14.05	20.92	34.03		PR	14.05	20.94	28.43
ID	14.05	20.92	28.43		RI	16.75	21.56	28.43
IL	14.05	20.92	28.43		SC	14.05	20.94	28.43
IN	14.05	20.92	28.43		SD	15.70	20.92	38.00
KS	14.05	20.92	35.48		TN	14.05	20.94	28.43
KY	14.05	26.81	36.35		TX	14.05	20.94	28.43
LA	14.05	20.94	28.43		UT	14.09	20.92	44.27
MA	23.47	20.92	28.43		VA	14.05	20.92	28.43
MD	14.05	20.92	28.43		VI	14.05	20.94	28.43
ME	23.47	20.92	28.43		VT	15.08	20.92	28.43
MI	14.05	20.92	28.43		WA	22.39	30.69	36.45
MN	14.05	20.92	28.43		WI	14.05	20.92	28.43
MO	14.05	20.92	28.43		WV	14.05	20.92	28.43
MS	14.05	20.94	28.43		WY	19.59	27.91	39.64
MT	14.05	20.92	35.48					

2012 National Monthly Payment Amounts for Stationary Oxygen Equipment
CR 7635 implements the 2012 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2012. As required by statute, the payment amount must be adjusted annually, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE).

The updated national 2012 monthly payment amount of $176.06 for stationary oxygen equipment codes is included in the DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2012 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment
CR 7635 also updates the 2012 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in MLN Matters® Articles, MM6792 *Maintenance and Servicing Payments for Certain Oxygen Equipment*, which you can find at **http://www.cms.gov/MLNMattersArticles/downloads/MM6792.pdf** and MM6990 *Clarification of the Date of Service for Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010*, which you can find at **https://www.cms.gov/MLNMattersArticles/downloads/MM6990.pdf** on the CMS website.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2011 maintenance and servicing fee is adjusted by the 2.4 percent MFP-adjusted covered item update factor to yield a CY 2012 maintenance and servicing fee of $67.51 for oxygen concentrators and transfilling equipment.

Additional Information
You can find the official instruction, CR 7635, issued to your carrier, DME MAC, FI, A/B MAC, or RHHI by visiting **http://www.cms.gov/Transmittals/downloads/R2340CP.pdf** on the CMS website. You will find the updated "*Medicare Claims Processing Manual*", Chapter 23 (Fee Schedule Administration and Coding Requirements, Section 60.3 (Gap-filling DMEPOS Fees) as an attachment to that CR.

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

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

MLN Matters Number: MM6421 Revised
Related CR Release Date: October 14, 2011
Related CR Transmittal #: R963OTN

Related Change Request (CR) #: 6421
Effective Dates: Phase 1 - October 1, 2009
Implementation Date: Phase 1 - October 5, 2009
Phase 2 - To be announced

Note: *This article was to reflect a revised CR6421. The CR was revised to delete chiropractors from the list of providers on page 2 who may order and/or refer. As a result, the CR release date transmittal number and Web address for accessing the CR were revised. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "To Be Announced" implementation and effective dates in this article are the correct dates.*

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

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

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

The providers who can order/refer are:

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

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

Key Points

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

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

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

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

- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:

    - Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to **http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf** on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.

    - Checking the Ordering Referring Report at **http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage** on the CMS website.

- **I don't have an enrollment record. What should I do?** Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see "Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" at **http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf** on the CMS website.

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

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R963OTN.pdf** on the CMS website.

Further Details on the Revalidation of Provider Enrollment Information (SE1126) (GEN)

MLN Matters® Number: SE1126 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on November 1, 2011, to provide a new web address for payment of the Medicare enrollment application fees. Clarification language was also added on page 3, regarding the revalidation process. All other information remains the same.*

Provider Types Affected
This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who enrolled in Medicare prior to March 25, 2011, via Medicare's Contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed
Impact to You
In Change Request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register." A related MLN Matters® Article is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf** on the CMS website. **This article provides no new policy, but**

only provides further information regarding the revalidation requirements based on Section 6401 (a) of the *Affordable Care Act*.

What You Need to Know
All providers and suppliers enrolled with Medicare prior to March 25, 2011, must revalidate their enrollment information, but only after receiving notification from their MAC.

Special Note: *The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers should continue to submit routine changes - address updates, reassignments, additions to practices, changes in authorized officials, information updates, etc - as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.*

What You Need to Do
When you receive notification from your MAC to revalidate:

- Update your enrollment through Internet-based PECOS or complete the 855;
- Sign the certification statement on the application;
- If applicable, pay your fee by going to **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do**; and
- Mail your supporting documents and certification statement to your MAC.

See the Background and Additional Information sections of this article for further details about these changes.

Background
Section 6401 (a) of the *Affordable Care Act* established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. **Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are generally not impacted.**

CMS has reevaluated the revalidation requirement in the *Affordable Care Act*, and believes it affords the flexibility to extend the revalidation period for another 2 years. This will allow for a smoother process for providers and contractors. Revalidation notices will now be sent through March of 2015. **IMPORTANT:** This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor respond to the request by completing the application either through internet-based PECOS or by completing the appropriate 855 application form.

Therefore, between now and 2015, MACs will send out revalidation notices on an intermittent, but regular basis to begin the revalidation process for each -provider and supplier. Providers and suppliers must submit the revalidation application only after being asked by their MAC to do so. Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

The first set of revalidation notices went to providers who are billing, but are not currently in PECOS. To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

- **For providers NOT in PECOS** - the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.
- **For providers in PECOS** - the revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found at **http://www.CMS.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf** on the CMS website.

Note: *CMS has structured the revalidation processes to reduce the burden on the providers by implementing innovative technologies and streamlining the enrollment and revalidation processes. CMS will continue to provide updates as progress is made on these efforts.*

The most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to **https://pecos.cms.hhs.gov** on the CMS website. PECOS allows you to review information currently on file, update and submit your revalidation via the Internet. Once submitted, YOU MUST print, sign, date, and mail the certification statement along with all required supporting documentation to the appropriate MAC IMMEDIATELY.

Section 6401(a) of the *Affordable Care Act* also requires the Secretary to impose a fee on each "institutional provider of medical or other items or services and suppliers." The application fee is $505 for Calendar Year (CY) 2011. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

All institutional providers (i.e., all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit an enrollment fee (reference 42 CFR 424.514) with their revalidation. In mid September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee. You may submit your fee by ACH debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do** and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the Medicare contractor along with the Certification Statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid.

Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. **Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges.**

Additional Information
For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf** on the CMS website.

For more information about the application fee payment process, refer to MLN Matters® Article SE1130, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1130.pdf** on the CMS website.

The MLN® fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and can be found at **http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf** on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to **https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin** to create an account.

A sample letter requesting providers to review, update, and certify their enrollment information is available at **http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf** on the CMS website.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment web page at **http://www.cms.gov/MedicareProviderSupEnroll** on the CMS website.

If you have questions, contact your Medicare contractor. Medicare provider enrollment contact information for each State can be found at **http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf** on the CMS website.

Implementation of Pay.gov Application Fee Collection Process through PECOS (SE1130) (GEN)

MLN Matters® Number: SE1130
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: October 3, 2011
Implementation Date: N/A

Provider Types Affected
This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers, (except physicians and non-physician practitioners who are not required to pay an application fee), who are initially enrolling in Medicare, adding a practice location, or revalidating their enrollment information, and do so by submitting one of the following paper Medicare

enrollment applications or the associated Internet-based Provider Enrollment, Chain and Ownership System (PECOS) enrollment applications:

- CMS 855A - Medicare Enrollment Application for Institutional Providers;
- CMS 855B - Medicare Enrollment Application for Clinics, Group Practices; and Certain Other Suppliers; and
- CMS 855S - Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers.

Provider Action Needed

Impact to You

Currently, providers or suppliers use **Pay.gov** to make Medicare application fee payments electronically. This article announces a change to this website address to submit your application fee.

What You Need to Know

The changes outlined below have no effect on the **Pay.gov** payment collection process. CMS is simply revising the way providers submit their application fee to improve the efficiency of the payment, collection, and accounting process.

What You Need to Do

Use the following address to make your application fee payments: **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do** on the CMS website. Please update any bookmarks you and your staffs may have in place to the new address.

Background

In February 2011, CMS published a final rule, CMS-6028-FC, with provisions related to the submission of application fees as part of the provider enrollment process. An application fee and/or hardship exception must be submitted with any application received from institutional providers initially enrolling in Medicare, adding a practice location, or revalidating their enrollment on or after March 25, 2011.

Changes for Making Medicare Application Payments

Internet based PECOS On-Line Application Submitters:

For those who submit applications online via the PECOS website (also referred to as PECOS Provider Interface (or PECOS PI)), you will no longer have to separately access **Pay.gov** to make your application fee payments. Instead, as you proceed through the Internet based PECOS application process, if a fee is required, you will be prompted to submit your payment by credit card or ACH debit card. Once your payment transaction is complete, you will be automatically returned to the PECOS website to complete the remaining part of your application. PECOS will track the collection transaction and will update payment status, allowing your application to be processed.

855 Paper Application Submitters:

For providers who continue to use the 855 paper enrollment application, you will now submit your application fee using the following URL: **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do** on the CMS website.
Complete the Medicare Application Fee form and click the 'PAY NOW' button. You will be redirected to enter and submit payment collection information. At the conclusion of the collection process, you will receive a receipt indicating the status of your payment. Please print a copy for your records. We strongly recommend that you attach this receipt to the completed CMS-855 application submitted to your Medicare contractor.

Paper Application Submitters-Interim Procedures

Through December 31, 2011, if you go to **Pay.gov** directly, you will be redirected to the correct URL: **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do**, on the CMS website. Please update any bookmarks you may have in place.

After December 31, 2011, you will be required to use the URL **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do** on the CMS website to submit your application fee.

Additional Information

More information about the enrollment process, the required fees, and the hardship exceptions process can be found in the MLN Matters® Article MM7350, available at **http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf** on the CMS website.

More information on revalidation can be found in SE1126, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1126.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.

Implementation of Provider Enrollment Provisions in CMS-6028-FC (MM7350) (GEN)

MLN Matters® Number: MM7350 Revised
Related CR Release Date: March 23, 2011
Related CR Transmittal #: R371PI

Related Change Request (CR) #: 7350
Effective Date: March 25, 2011
Implementation Date: March 25, 2011

Note: *MM7350 was revised on October 31, 2011, to provide a new Web address for making payment of the application fees. All other information remains the same.*

Provider Types Affected
All providers and suppliers submitting enrollment applications to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC) are affected by this article.

Provider Action Needed
Impact to You
The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register."

What You Need to Know
This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

What You Need to Do
This article is based on Change Request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

Background
CR7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the "*Medicare Program Integrity Manual*." Those manual sections are attached to CR7350 and are summarized as follows:

Screening Processes
Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the "*Program Integrity Manual*" (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application Fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. **Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.**

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is $505.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;
- An application that was rejected prior to the Medicare Contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to **https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do** and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship Exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter **must** accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter **must** accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. **During this review period, the contractor will not begin processing the provider's application.** CMS will communicate its decision to the institutional provider and the contractor via letter.

IMPORTANT: *In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.*

Review of Hardship Exception Request

As already stated, the application fee for CY 2011 is $505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. **It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship.** The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that **may** suggest that a hardship exception is appropriate include the following:

(a) Considerable bad debt expenses,
(b) Significant amount of charity care/financial assistance furnished to patients,
(c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;
(d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or
(e) Whether the provider is enrolling in a geographic area that is a P residentially-declared disaster under the *Robert T. Stafford Disaster Relief and Emergency Assistance Act*, 42 U.S.C. 5121-5206 (*Stafford Act*).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. **Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.**

Appeal of the Denial of Hardship Exception Decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the "*Program Integrity Manual*" (PIM), which is attached to CR7350.

Temporary Moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the Federal Register. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

Additional Information

The official instruction, CR7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at **http://www.cms.gov/transmittals/downloads/R371PI.pdf** on the CMS website.

Complete details regarding this issue, as defined in the PIM revisions, are attached to CR7350.

MLN Matters® article SE1126, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf**, has further details on the *Affordable Care Act*-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to MLN Matters® article SE1130, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1130.pdf** on the CMS website.

A sample letter requesting providers to review, update, and certify their enrollment information is available at **http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf** on the CMS website.

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

Important Update Regarding 5010/D.0 Implementation - Action Needed Now (SE1131) (GEN)

MLN Matters® Number: SE1131
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HH+H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
You and your billing and software vendors must be ready to begin processing the *Health Insurance Portability and Accountability Act* (HIPAA), Versions 5010 & D.0 production transactions by December 31, 2011. Beginning January 1, 2012, all electronic claims, eligibility and claim status inquiries, must use Versions 5010 or D.0. Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in the 5010 version.

What You Need to Know
You must comply with this important deadline to avoid delays in payments for Medicare Fee-For-Service (FFS) claims after December 31, 2011. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

What You Need to Do
Contact your MACs to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which are available at **http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp** on the CMS website. Part A providers may download the free PC-Print software to view and print compliance HIPAA 5010 835 remittance advices, which is available on your A/B MACs website. Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Background
HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

The implementation of HIPAA 5010 and the National Council for Prescription Drug Programs (NCPDP) Version D.0 presents substantial changes in the content of the data that you submit with your claims, as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

Version 5010 refers to the revised set of HIPAA transaction standards adopted to replace the current Version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

All HIPAA covered entities must transition to Version 5010 by **January 1, 2012**. Any electronic transaction for which a standard has been adopted must be submitted using Version 5010 on or after January 1, 2012. Electronic transactions that do not use Version 5010 are not compliant with HIPAA and **will be rejected.**

To allow time for testing, CMS began accepting electronic transactions using either Version 4010/4010A or Version 5010 standards on January 1, 2011, and will continue to do so through December 31, 2011. This process allows a provider and its vendors to complete end-to-end testing with Medicare contractors and demonstrate that they are able to operate in production mode with Versions 5010 and D.0.

Note: *HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with FFS Medicare.* ***Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business as well.***

Are You at Risk of Missing the Deadline?
If you can answer **NO** to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and not being able to submit claims:

1. Have you contacted your software vendor (if applicable) to ensure that they are on track to meet the deadline or contacted your MAC to get the free Version 5010 software (PC-Ace Pro32)?

2. Alternatively, have you contacted clearinghouses or billing services to have them translate your Version 4010 transactions to Version 5010 (if not converting your older software)?

3. Have you identified changes to data reporting requirements?

4. Have you started to test with your trading partners, which began on January 1, 2011?

5. Have you started testing with your MAC, which is required before being able to submit bills with the Version 5010?

6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

Additional Information
MLN Matters® Article #MM7466, "Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1," is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM7466.pdf** on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0," is available at **http://www.cms.gov/Versions5010andD0/downloads/w5010TransitionFctSht.pdf** on the CMS website.

MLN Matters® Special Edition Article #SE1106 titled "Important Reminders about HIPAA 5010 & D.0 Implementation," is available at **http://www.cms.gov/MLNMattersArticles/Downloads/SE1106.pdf** on the CMS website.

Additional educational resources about HIPAA 5010 & D.0 are available at **http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp** on the CMS website.

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

January 2012 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7624) (DRU)

MLN Matters® Number: MM7624
Related CR Release Date: October 27, 2011
Related CR Transmittal #: R2331CP

Related Change Request (CR) #: CR 7624
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

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

Provider Action Needed
This article is based on Change Request (CR) 7624 which instructs your Medicare contractors to download and implement the January 2012 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised October 2011, July 2011, April 2011, and January 2011 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2012, with dates of service January 1, 2012, through March 31, 2012.

Background
The *Medicare Modernization Act of 2003* (MMA; Section 303(c); see **http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf** on the Centers for Medicare & Medicaid Services (CMS) website) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis. The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "*Medicare Claims Processing Manual*" (Chapter 4, Section 50; see **http://www.cms.gov/manuals/downloads/clm104c04.pdf** on the CMS website.

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

Files	Effective for Dates of Service
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011

Additional Information
The official instruction, CR7624, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2331CP.pdf** on the CMS website.

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

January 2012 Quarterly Update for the DMEPOS Competitive Bidding Program (MM7632) (GEN)

MLN Matters® Number: MM7632
Related CR Release Date: November 4, 2011
Related CR Transmittal #: R2341CP

Related Change Request (CR) #: CR 7632
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
Providers and suppliers submitting claims to Medicare Durable Medical Equipment (DME) Medicare Administrative Contractors (DME MACs), or Medicare Regional Home Health Intermediaries (RHHIs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7632 which provides the January 2012 quarterly update for the DMEPOS Competitive Bidding Program files. CR7632 contains necessary changes to the Healthcare Common Procedure Coding System (HCPCS), Competitive Bidding Area (CBA) ZIP Code, and CBA Pricing files effective January 1, 2012. Be sure billing staff are aware of these changes.

Background
Section 302 of the *Medicare Modernization Act of 2003* (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid.

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

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

MIPPA requires the competition for Round Two to occur in 2011 in 70 additional metropolitan statistical areas (MSAs) and authorizes competition for national mail order items and services after 2010. The *Affordable Care Act of 2010* (ACA) expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program on the CMS website at **http://www.cms.gov/DMEPOSCompetitiveBid/**.

Competitive Bidding ZIP Codes
For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA. ZIP codes are established by the United States Postal Service (USPS). the CBA numbers and associated names are as follows:

- 16740 - Charlotte-Gastonia-Concord, NC-SC (non-mail order and mail order)
- 16741 - Charlotte-Gastonia-Concord, NC-SC (mail order only)
- 17140 - Cincinnati-Middletown, OH-KY-IN (non-mail order and mail order)
- 17141 - Cincinnati-Middletown, OH-KY-IN (mail order only)
- 17460 - Cleveland-Elyria-Mentor, OH (non-mail order and mail order)
- 17461 - Cleveland-Elyria-Mentor, OH (mail order only)
- 19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
- 19101 - Dallas-Fort Worth-Arlington, TX (mail order only)
- 28140 - Kansas City, MO-KS (non-mail order and mail order)
- 28141 - Kansas City, MO-KS (mail order only)
- 33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
- 33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
- 36740 - Orlando- Kissimmee, FL (non-mail order and mail -order)
- 36741 - Orlando- Kissimmee, FL (mail order only)
- 38300 - Pittsburgh, PA (non-mail order and mail order)
- 38301 - Pittsburgh, PA (mail order only)
- 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order)
- 40141 - Riverside-San Bernardino-Ontario, CA (mail order only)

Updates to the ZIP Code Files:
Six new ZIP codes have been added to the ZIP code file to conform with United States Postal Service ZIP code changes within CBAs:

ZIP	CBA
75033	19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
75033	19101 - Dallas-Fort Worth-Arlington, TX (mail order only)
33106	33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
33106	33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
33206	33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
33206	33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)

Updates to the HCPCS and Single Payment Amount Files:
There are no updates to these files at this time.

Public Use Files
The competitive bidding ZIP codes and single payment amounts per product category and CBA are available on the CBIC Website for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The CBIC Website can be accessed at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf** or by going to **http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp** on the CMS website. These files can be used to identify when a specific item furnished to a beneficiary is subject to the DMEPOS competitive bidding program.

Single Payment Amount
Currently, Medicare payment for most DMEPOS items is based on fee schedules in most areas of the country. However, the *Social Security Act* (Section 1847; see **http://www.ssa.gov/OP_Home/ssact/title18/1847.htm** on the Internet) mandates that competitive bidding single payment amounts replace the current DMEPOS fee schedule payment amounts for competitively bid items in CBAs. Therefore, the single payment amount is the Medicare allowed payment amount for competitively bid items for beneficiaries who reside in the Round One Rebid CBAs. Medicare pays contract suppliers 80 percent of the single payment amount for each competitively bid item. Beneficiaries are responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items. Single payment amounts remain the same throughout the term of suppliers' contracts.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one

through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months. The changes to the power wheelchair payment rules made by section 3136 of the ACA (see **http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf** on the Internet) do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011, or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the fee schedule amount for the first three months and 75 percent of the fee schedule amounts paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by the Section 3136 of the ACA, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount.

For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.

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

Additional Information
The official instruction, CR7632, issued to your DME MACs and RHHIs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2341CP.pdf** on the CMS website.

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

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

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

Note: *This article was revised on November 18, 2011, to correct two dates in the example provided at the top of page 3. All other information remains the same.*

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

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

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

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

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

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

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

A single payment ($66 for dates of service July 1, 2010 through December 31, 2010) is made per beneficiary regardless of:
- The number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment);
- When the maintenance and servicing is performed during each 6-month period; or
- How often the equipment must be maintained and serviced.

You must make at least one maintenance/servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. For example:
- 36th monthly payment amount made for month ending June 30, 2010;
- 6-month period with no payment ends December 31, 2010;
- Maintenance and servicing payment may begin on January 1, 2011, provided warranty coverage ended on June 30, 2010, or earlier;
    - You must make at least one in-home visit during January 2011; and
    - Payment covers all maintenance and servicing through June 30, 2011.
- Second maintenance and servicing payment may be made on July 1, 2011;
    - You must make at least one in-home visit during July 2011, and
    - Payment covers all maintenance and servicing through December 31, 2011.

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

Billing Guidance
You should use:
- Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E0433, or K0738 along with the MS modifier to bill and receive payment for maintenance and servicing of oxygen equipment other than gaseous or liquid oxygen equipment;
- HCPCS code E1390 for maintenance and servicing for a beneficiary using a single delivery port stationary oxygen concentrator or portable concentrator, and for maintenance and servicing for beneficiaries renting a combination of single delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code E1391 for maintenance and servicing for a beneficiary using a dual delivery port stationary oxygen concentrator or for beneficiaries renting a combination of dual delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;

- HCPCS code K0738 only in situations in which the beneficiary owns stationary oxygen equipment, but rents gaseous oxygen transfilling equipment; and
- HCPCS code E0433 only in situations in which the beneficiary owns stationary equipment but rents liquid oxygen transfilling equipment.

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

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

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

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

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

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

When denying such claims, they will:

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

Additional Information

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

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

Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) (MM7492) (GEN)

MLN Matters® Number: MM7492
Related CR Release Date: August 19, 2011
Related CR Transmittal #: R950OTN

Related Change Request (CR) #: 7492
Effective Date: October 1, 2013
Implementation Date: January 1, 2012

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

Provider Action Needed
For dates of service on and after October 1, 2013, entities covered under the *Health Insurance Portability and Accountability Act* (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key Points of CR7492
General Reporting of ICD-10
As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to **http://www.cms.gov/ICD10** for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General Claims Submissions Information
ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that Span the ICD-10 Implementation Date
The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A - Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (*incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)*	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health - Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34X	Home Health - (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A - Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
82X	Hospice - Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83X	Hospice - Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	**THROUGH**

Table C - Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	**FROM**

Table D -Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	**FROM**

Additional Information
The official instruction, CR7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R950OTN.pdf** on the CMS website.

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

Medicare Pilot Project for Electronic Submission of Medical Documentation (esMD) (SE1110) (GEN)

MLN Matters® Number: SE1110 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on October 14, 2011, to correct the contractor for DME MAC C on page 5. It had incorrectly listed Palmetto GBA. The correct contractor is CGS Administrators, LLC. All other information remains the same.*

Provider Types Affected
This Special Edition (SE) affects all Medicare Fee-For-Service (FFS) providers who submit medical documentation to Medicare review contractors.

Provider Action Needed
Impact to You
Each year, the Medicare Fee-For-Service (FFS) Program makes billions of dollars in estimated improper payments. The Centers for Medicare & Medicaid Services (CMS) employs several types of Medicare review contractors to measure, prevent, identify, and correct these improper payments. Review contractors find the improper payments by requesting medical documentation from each provider who submitted a questionable claim. The review contractor then manually reviews the claims against the submitted medical documentation to verify the providers' compliance with Medicare's rules.

Currently, review contractors request medical documentation by sending a paper letter to the provider. The provider has two options for submitting the requested records: 1) mail paper, or 2) send a fax.

What You Need to Know
Medicare's Electronic Submission of Medical Documentation (esMD) pilot project gives some providers a new mechanism for submitting medical documentation to review contractors. A list of review contractors that will accept esMD transactions can be found at **http://go.usa.gov/kr4** on the Internet.

The esMD pilot will begin in September of 2011.

The primary intent of esMD is to reduce provider costs and cycle time by minimizing and eventually eliminating paper processing and mailing of medical documentation to review contractors. A secondary goal of esMD is to reduce costs and time at review contractors.

In order to send medical documentation electronically to review contractors, Medicare providers, including physicians, hospitals, and suppliers, must obtain access to a CONNECT-compatible gateway.

- Certain larger providers, such as hospital chains, may choose to build their own gateway.
- Many providers may choose to obtain gateway services by entering into a contract or other arrangement with a Health Information Handler (HIH) that offers esMD gateway services.

A list of HIHs that offer esMD services as of September 2011 can be found in the "Key Points" section of this article. An updated listing of the HIHs that have been approved by CMS to offer esMD services can also be found at **http://go.usa.gov/krg** on the Internet.

CMS does not set the price that an HIH may charge a provider for esMD services. Providers who believe it may be more efficient to respond to documentation requests electronically are encouraged to contact one or more of the HIHs to determine if esMD services are available at a reasonable price.

What You Need to Do

You should know that esMD is completely voluntary. You may continue to mail or fax documentation to your review contractor.

The initial esMD system accepts Portable Document Format (PDF) files, which means that even those providers who have paper records may utilize esMD services as long as there is a mechanism to scan the paper records into PDF files. Some HIHs may offer scanning services in addition to their esMD services.

Key Points

The following are tentative schedules of when HIHs will be ready to offer esMD services and when Review Contractors will be ready to accept esMD:

HIH/Web Address	Scheduled Readiness*
HealthPort (**http://www.healthport.com**)	September 2011
IVANS (**http://www.ivans.com**)	September 2011
MRO (**http://www.mrocorp.com**)	September 2011
NaviNet (**http://www.navinet.net**)	September 2011
RISARC (**http://www.risarc.com**)	September 2011
eSolutions (**http://www.ecorpnet.com**	November 2011
Cobius (**http://www.cobius.com**)	November 2011
IOD, Inc. (**http://www.iodincorporated.com**)	November 2011
Proficient Health (**http://www.proficienthealth.com**)	November 2011
Craneware (**http://www.craneware.com**)	November 2011
MDClick (**http://www.mdclick.com**)	November 2011
Medical Electronic Attachment (**http://www.mea-fast.com**)	November 2011
EHR Doctors (**http://www.ehrdoctors.com**)	November 2011
ApeniMED (**http://www.Apenimed.com**)	November 2011
HealthIT+ (**http://www.healthitplus.com**)	November 2011
ECC Technologies (**http://www.ecctec.com**)	January 2012
Stratice Healthcare (**http://straticehealthcare.com/**)	January 2012
AT&T (**http://www.att.com/healthcare**)	January 2012
CureMD (**http://www.curemd.com**)	January 2012
MediConnect (**http://www.mediconnect.net**)	January 2012
MediCopy (**http://www.medicopy.net**)	January 2012
Cal eConnect (**http://www.caleconnect.org**)	January 2012
LMRP Manager (**http://www.racmanager.com**)	January 2012
SSI (**http://www.thessigroup.com/**)	January 2012
Verisma Systems (**http://www.verismasystems.com**)	January 2012
Zydoc (**http://www.zydoc.com**)	January 2012
Ivertex (**http://www.ivertex.com**)	April 2012

Medicare review contractors include the Recovery Auditors (RACs), Medicare Administrative Contractors (MACs), the Comprehensive Error Rate Testing (CERT) contractor, the Program Error Rate Measurement (PERM) contractor, and Zone Program Integrity (ZPIC) contractors.

The following shows when some of these contractors will be accepting esMD transactions:

Review Contractors	Scheduled Readiness*
RAC A - Diversified Collection Services (DCS)	September 2011
RAC B - CGI Technologies and Solutions	September 2011
MAC J1 and J11 - Palmetto GBA	September 2011
MAC J3 - Noridian Administrative Services	September 2011
MAC J4 - Trailblazer Health Enterprises	September 2011
MAC J5 - Wisconsin Physicians Services Health Insurance Corporation	September 2011
MAC J9 - First Coast Service Options	September 2011
MAC J12 - Highmark Medicare Services	September 2011
MAC J14 - NHIC	September 2011
DME MAC A - NHIC	September 2011
DME MAC D - Noridian Administrative Services, LLC	September 2011
CERT - Livanta	September 2011
PERM - A+ Government Solutions	September 2011
MAC J10 - Cahaba Government Benefit Administrators	November 2011
MAC J13 - National Government Services	November 2011
DME MAC B - NGS	November 2011
ZPIC 1 - Safeguard Services LLC	November 2011
ZPIC 7 - Safeguard Services LLC	November 2011
RAC D - HealthDataInsights	November 2011
MAC J15 - CIGNA Government Services, LLC	January 2012
DME MAC C - CGS Administrators, LLC	January 2012

These are anticipated dates and subject to change. Please check the esMD website (http://www.cms.gov/ESMD) for more information.

NOTE: *CMS expects that the Region C and D Recovery Auditors and remaining MACs will begin accepting esMD transactions within the next 12 months.*

Additional Information
If you have any questions, please contact the review contractor to which you wish to send esMD transactions. MAC toll-free numbers can be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

For more information, visit the esMD webpage at **http://www.cms.gov/esmd** on the CMS website. You might also try the Twitter Link, which is @CMSGov (Look for #CMS_esMD).

For more information on the Medicare Recovery Audit program, see the MLN Matters® article SE1024 at **http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf** on the CMS website. You may contact your Recovery Auditor for questions you have of them. Their contact information is at **http://www.cms.gov/RAC/Downloads/RACcontactinfo.pdf** on the CMS website.

Revised - New Qualified Independent Contractor (QIC) - C2C Solutions, Inc. (GEN)

Reconsideration requests, the second level in the Medicare appeals process, are processed by the Qualified Independent Contractor (QIC), who is currently RiverTrust Solutions. Effective November 15, 2011, C2C Solutions, Inc. will take over the QIC contract and begin processing reconsideration requests for all four of the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

All requests for reconsideration received by RiverTrust Solutions, on or after November 15, 2011 will be forwarded to the new Qualified Independent Contract (QIC). All requests for reconsideration received on or before November 14, 2011 will continue to be processed by RiverTrust Solutions.

Effective, November 15, 2011 DMEPOS suppliers should send all requests for reconsideration to C2C Solutions, Inc. Below is the address and contact information for C2C Solutions, Inc.

C2C Solutions, Inc.
Attn: DME QIC
P.O. Box 44013
Jacksonville, FL 32231-4013

Web site: **http://www.C2Cinc.com**

C2C Solutions, Inc. also holds the QIC contract for Medicare Part B Reconsiderations in the Northern Jurisdiction. The DME MACs and C2C Solutions, Inc. will strive to make this transition as seamless as possible for DMEPOS suppliers.

Pharmacy Billing for Drugs Provided "Incident To" a Physician Service (MM7397) (DRU)

MLN Matters® Number: MM7397 Revised
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R2312CP
Related Change Request (CR) #: 7397
Effective Date: January 1, 2012
Implementation Date: January 1, 2012

Note: *This article was revised on September 26, 2011, to reflect the revised CR7397 issued on September 23. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.*

Provider Types Affected
Pharmacies that submit claims for drugs to Medicare contractors (Fiscal Intermediaries (FIs), Carriers, Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs) are affected.

What You Should Know
This article is based on Change Request (CR) 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided "incident to" a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined.

This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

Background
Pharmacies billing drugs
Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

- Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.

- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When drugs may not be billed by pharmacies to Medicare Part B
Pharmacies, suppliers and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration "incident to" a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician's office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered "incident to" a physician's service and pharmacies may not bill Medicare Part B under the "incident to" provision.

Payment limits
The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under the Outpatient Prospective Payment System (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Additional Information
The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at **http://www.cms.gov/Transmittals/downloads/R2312CP.pdf** on the Centers for Medicare & Medicaid Services (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.

The following manual sections regarding billing drugs and biological and "incident to" services may be helpful:

- "*Medicare Claims Processing Manual*", chapter 17, sections 20.1.3 and 50.B, available at **http://www.cms.gov/manuals/downloads/clm104c17.pdf** and
- "*Medicare Benefit Policy Manual*", chapter 15, sections 50.3 and 60.1, available at **http://www.cms.gov/manuals/Downloads/bp102c15.pdf** on the CMS website.

Populating REF Segment - Other Claim Related Adjustment - for Healthcare Claim Payment/Advice or Transaction 835 Version 5010A1 (MM7484) (GEN)

MLN Matters® Number: MM7484 Revised
Related CR Release Date: September 2, 2011
Related CR Transmittal #: R959OTN

Related Change Request (CR) #: CR 7484
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: *This article was revised on September 6, 2011, due to changes in CR7484. The CR was revised to add qualifier "FI" in Loop 2100 NM1 - Service Provider Name under special situations where the NPI is not available - enabling Medicare to report the Federal Taxpayer's Identification Number instead of NPI if NPI is not available for the Rendering Provider and the Rendering provider is different from the Payee. The CR release date, transmittal number, and the Web address for accessing the CR were also revised. All other information remains the same.*

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

Provider Action Needed
Impact to You
The Centers for Medicare and Medicaid Services (CMS) has decided that populating the Healthcare Claim Payment/Advice or Transaction 835 version 5010A1 REF segment (Other Claim Related Adjustment) at Loop 2100 (for Part B) would provide useful information to providers and suppliers, and starting in January 2012, this segment will be populated for the Part B remittance advice.

What You Need to Know
CR7484, from which this article is taken, instructs Medicare systems, effective January 1, 2012, to populate the REF segment (Other Claim Related Adjustment) at Loop 2100 with qualifiers designated in the updated Flat File attached to CR7484. Note that CR also updates the 835 flat file by adding:

- PLB Code 90;
- Qualifier "PQ" to be used in Loop 1000B REF - Payee Additional Information under some special situations where the National Provider Identifier (NPI) is not available; and
- Qualifier "F1" to be used in Loop 2100 NM1 - service payable under some special situations where NPI is not available.

What You Need to Do
You should make sure that your billing staffs are aware of this change.

Background
Currently the Healthcare Claim Payment/Advice or Transaction 835 REF segment (Other Claim Related Adjustment) at Loop 2100 is not being populated for the Part B remittance advice, and the 835 Flat File identifies this with a note: "N/U by Part B."

CMS has decided that using this segment would provide useful information to providers and suppliers. Therefore, CR7484, from which this article is taken, instructs the VIPS Medicare System (VMS) and the Multi Carrier System (MCS) to populate this segment, effective January 1, 2012, under specific situations (e.g., for cost avoid claims) using one of the qualifiers included in the updated Flat File that is an attachment to CR7484.

Specifically, VMS and MCS will use one of the following Reference Identification Qualifiers in REF01 as appropriate:

- 28: Employee Identification Number
- 6P: Group Number (When they use this 6P qualifier, they will also populate NM1 - Corrected Priority Payer Name segment at Loop 2100 and REF02 with the Other Insured Group Number for the payer identified in NM1, and use Claim Status Code 2 in CLP02 in CLP - Claim Payment Information segment at Loop 2100);
- EA: Medical Record Identification Number
- F8: Original Reference

NOTE: *Medicare will update Medicare Remit Easy Print (MREP) software to include this additional REF segment in the MREP Remittance Advice for version 5010A1.*

Additional Information
You can find the official instruction, CR7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R959OTN.pdf** on the CMS website. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

Additionally, you can learn more about CMS's implementation activities to convert from *Health Insurance Portability and Accountability Act* (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010A1 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0, by going to **http://www.cms.gov/MFFS5010D0/01_Overview.asp#TopOfPage** on the CMS website.

If you have any questions, please contact your 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.

Predictive Modeling Analysis of Medicare Claims (SE1133) (GEN)

MLN Matters® Number: SE1133
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who submit Fee-For-Service (FFS) claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment (DME) MACs, and Home Health and Hospice MACs (HH+H MACs)).

What Providers Need to Know
Impact to You
As of June 30, 2011, the Centers for Medicare & Medicaid Services (CMS), has implemented a predictive analytics system that will analyze all Medicare FFS claims to detect potentially fraudulent activity.

What You Need to Know
The predictive analytics system uses algorithms and models to examine Medicare claims in real time to flag suspicious billing. This article briefly explains the predictive modeling system, its purpose, and how CMS is incorporating the system into its claims payment process.

What You Need to Do
See the Background and Additional Information sections of this article for more information about this change.

Background
Section 4241 of the *Small Business Jobs Act of 2010* (SBJA) mandated that the CMS implement a predictive analytics system to analyze Medicare claims to detect patterns that present a high risk of fraudulent activity. Signed by the President in Fall 2010, the SBJA enables CMS to employ real-time, pre-payment claims analysis to identify emerging trends of potentially fraudulent activity. This new process is similar to the pre-payment analysis already done by the financial and credit card industries. The entire text of the SBJA is available at **http://www.gpo.gov/fdsys/pkg/BILLS-111hr5297enr/pdf/BILLS-111hr5297enr.pdf** on the Internet.

Real Time Claims Streaming to Build Profiles and Create Risk Scores
As of June 30, 2011, CMS is streaming all Medicare FFS claims through its predictive modeling technology. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, billing patterns, and beneficiary utilization. These profiles enable CMS to create risk scores to estimate the likelihood of fraud and flag potentially fraudulent claims and billing patterns.

Risk scores enable CMS to quickly identify unusual billing activity and flag claims for more thorough review prior to releasing payment. The system automatically prioritizes claims, providers, beneficiaries, and networks that are generating the most alerts and highest risk scores. CMS is leveraging the benefits of its new high-tech system to complement, not replace, the expertise of its experienced analysts:

- Analysts review prioritized cases by closely reviewing claims histories, conducting interviews, and performing site visits as necessary.
- If an analyst finds only innocuous billing, the outcome is recorded directly into the predictive modeling system and the payment is released as usual. This feedback loop refines the predictive models and algorithms to better target truly fraudulent behavior.
- Analysts who find evidence or indicators of fraud will work with the CMS Center for Program Integrity, MACs, and Zone Program Integrity Contractors to enact targeted payment denials, and in cases of egregious fraud, revoke Medicare billing privileges. Program integrity entities may also, as appropriate, coordinate with law enforcement officials to investigate cases for criminal or civil penalties.

Effect of Risk Scores on Claims Payment
Risk scores alone do not initiate administrative action and serve only to alert CMS to the necessity of more careful review of claims activity. While providers will be unable to appeal risk scores, CMS's new technology will in no way alter a provider or supplier's existing rights to appeal administrative actions or overpayment recovery efforts.

Currently, CMS is not denying claims solely based on the alerts generated by predictive models. CMS is focused on developing and refining models that identify unusual behavior without disrupting its claims processing for Medicare providers.

Working closely with clinical experts across the country and of every provider specialty, CMS is developing and refining algorithms that reflect the complexities of medical treatment and billing. The new technology will ultimately benefit the program's many honest providers and suppliers by enabling the agency to prioritize the highest-risk cases for investigation and review. Prioritizing the alerts will minimize the disruption to providers who may occasionally exhibit unusual but honest billing.

CMS's predictive modeling technology also enables automated cross-checks of provider, beneficiary, and claim information against historical trends and external databases. Automating checks that were previously performed manually will help CMS to more quickly identify and resolve any issues that may delay payment to providers and suppliers. Even as CMS implements a more thorough claims screening process, the Agency remains dedicated to ensuring prompt payment for the providers. Prompt payment of claims is a statutory requirement; only in exceptional and urgent circumstances will CMS leverage its authority to waive prompt payment to conduct further investigation or review.

Additional Information
If you have any questions, please contact your Medicare contractor (carrier, FI, A/B MAC, HH+H 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.

Proof of Delivery and Delivery Methods (MM7410) (GEN)

MLN Matters® Number: MM7410 Revised
Related CR Release Date: September 30, 2011
Related CR Transmittal #: R389PI
Related Change Request (CR) #: 7410
Effective Date: October 31, 2011
Implementation Date: October 31, 2011

Note: *This article was revised on November 8, 2011, to add a reference to MM7452 (***http://www.cms.gov/MLNMattersArticles/downloads/MM7452.pdf***) that provides information regarding the prospective billing requirement for refills provided on a recurring basis. It was previously revised on November 1, 2011, to clarify the language in the "***What You Need to Know***" section. All other information is the same.*

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

What You Need to Know
CR 7410 modifies the number of days for a supplier to contact the beneficiary prior to dispensing a refill as well as the number of days to deliver a DMEPOS product prior to the end of usage for the current product. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This must be done to ensure that the refilled item is necessary and to confirm any changes or modifications to the order. CR7410 mandates that **contact with the beneficiary or designee regarding refills shall take place no sooner than 14 calendar days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier shall deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.**

Additional Information
The official instruction, CR 7410 issued to your DME MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R389PI.pdf** 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.

Reminder - Beneficiary Cost-Sharing for Medicare-Covered Preventive Services Under the Affordable Care Act (SE1129) (GEN)

MLN Matters® Number: SE1129
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation Date: NA

Provider Types Affected
This article is informational in nature and of interest to all providers who provide Medicare-covered preventive services to Medicare beneficiaries.

What You Need to Know
Effective for Dates of Service (DOS) on or after January 1, 2011, Medicare provides 100 percent payment (in other words, waives any deductible, coinsurance or copayment) for many Medicare-covered preventive services. This article serves as a reminder and quick reference for the changes to deductibles, copayments, or coinsurances for these services.

Background
Section 4104 of the *Affordable Care Act* waived deductibles, copayments, or coinsurance effective for DOS on or after January 1, 2011, for the following Medicare-covered preventive services:

- The Initial Preventive Physical Examination (IPPE or "Welcome to Medicare Visit");
- The Annual Wellness Visit (AWV); and
- Those preventive services that:
  - Are identified with a grade of A or B by the United States Preventive Services Task Force (UPSTF) for any indication or population; and
  - Are appropriate for the beneficiary.

Note: *To get more information about Medicare coverage, coding, and payment policies for these services, please consult the resources in the "Additional Information" section below.*

Copayment/Coinsurance and Deductibles
The table below provides information for the copayment/coinsurance and deductibles for Medicare-covered preventive services.

Note: *In some cases, the copayment, coinsurance and deductibles have not changed and will be the same for DOS prior to 1/1/11 as they are for DOS on or after 1/1/11.*

Preventive Benefit	Copayment/Coinsurance/ Deductible for DOS prior to 1/1/11	Copayment/Coinsurance/ Deductible for DOS on or after 1/1/11
IPPE/"Welcome to Medicare Visit"	For dates of service between January 1, 2009, and January 1, 2011, the deductible for the IPPE only is waived (not the screening electrocardiogram [EKG]). For DOS prior to 1/1/09, the deductible is not waived. Coinsurance or copayment still applies to both the IPPE and the screening EKG.	The beneficiary will pay nothing for the IPPE (there is no coinsurance or copayment and no Medicare Part B deductible). Coinsurance or copayment and the Medicare Part B deductible still apply to the screening electrocardiogram (EKG).
AWV	Medicare did not cover this service prior to 1/1/11	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). However, if a medically necessary Evaluation and Management service is also furnished with an AWV visit, coinsurance and deductible will apply for the additional services.
Colorectal Cancer Screening	For the Fecal Occult Blood Test (FOBT), the beneficiary will pay the coinsurance or copayment, but Medicare Part B deductible is waived. For the flexible sigmoidoscopy, coinsurance or copayment applies and the Medicare Part B deductible is waived. If you perform the procedure in a hospital outpatient department or ambulatory surgical center, the beneficiary pays 25% of the Medicare-approved amount. For the colonoscopy, coinsurance or copayment and the Medicare Part B deductible are waived. The Medicare law requires that a beneficiary must pay coinsurance, but not the Part B deductible, when a screening colonoscopy results in a biopsy or removal of a lesion or growth. For the barium enema, coinsurance or copayment applies and the Medicare Part B deductible is waived. If you perform the screening in a CAH, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the barium enema, coinsurance or copayment applies and the Medicare Part B deductible is waived. If you perform the screening in a Critical Access Hospital (CAH), the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	For the Fecal Occult Blood Test (FOBT), flexible sigmoidoscopy, and colonoscopy, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Bone Mass Measurements	Both the coinsurance or copayment and the Medicare Part B deductible apply.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Cardiovascular Screening Blood Tests	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes Screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Diabetes Self-Management Training (DSMT)	Both the coinsurance or copayment and the Medicare Part B deductible apply.	Both the coinsurance or copayment and the Medicare Part B deductible apply.

Preventive Benefit	Copayment/Coinsurance/ Deductible for DOS prior to 1/1/11	Copayment/Coinsurance/ Deductible for DOS on or after 1/1/11
Diabetes Supplies	Both the coinsurance or copayment and the Medicare Part B deductible apply.	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Glaucoma Screening	Both the coinsurance or copayment and the Medicare Part B deductible apply.	Both the coinsurance or copayment and the Medicare Part B deductible apply.
Hepatitis B Virus (HBV) Vaccination	Both the coinsurance or copayment and the Medicare Part B deductible apply.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Human Immunodeficiency Virus (HIV) Screening	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Medical Nutrition Therapy (MNT)	Both the coinsurance or copayment and the Medicare Part B deductible apply.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Pneumococcal Vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Prostate Cancer Screening	For the screening Prostate Specific Antigen (PSA) blood test, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the Digital Rectal Examination (DRE), both the coinsurance or copayment and the Medicare Part B deductible apply.	For the screening Prostate Specific Antigen (PSA) blood test, the beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible). For the Digital Rectal Examination (DRE), both the coinsurance or copayment and the Medicare Part B deductible apply.
Screening Mammography	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Screening Pap Test	For screening Pap test services paid under the Medicare Physician Fee Schedule (MPFS), the coinsurance or copayment applies and the Medicare Part B deductible is waived. For screening Pap test services paid under the Clinical Laboratory Fee Schedule, both the coinsurance or copayment and the Medicare Part B deductible are waived.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Screening Pelvic Examination (includes a clinical breast examination)	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Seasonal Influenza Virus Vaccination	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Smoking and Tobacco-Use Cessation Counseling Services and Counseling to Prevent Tobacco Use	Both the coinsurance or copayment and the Medicare Part B deductible apply	Asymptomatic beneficiaries will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible).
Ultrasound Screening for Abdominal Aortic Aneurysm	Coinsurance or copayment applies for this benefit. The Medicare Part B deductible is waived. Must be referred for this service as a result from an IPPE.	The beneficiary will pay nothing for this benefit (there is no coinsurance or copayment and no Medicare Part B deductible) if the referral for this service resulted from the IPPE

Additional Information
For more information about Medicare-covered preventive services, including coverage and payment policies, as well as

- Change Request 7012, "Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of the *Patient Protection and Affordable Health Care Act* (the *Affordable Care Act*), Removal of Barriers to Preventive Services in Medicare" is available at **http://www.cms.gov/Transmittals/downloads/R864OTN.pdf** on the Internet.

- "The Guide to Medicare Preventive Services," which contains coverage, coding, and payment information for all the services referenced above, is available at **http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the Internet.

- A complete listing of MLN® products related to Medicare-covered preventive services is available at **http://www.cms.gov/MLNProducts/downloads/education_products_prevserv.pdf** on the Internet.

Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number (MM7499) (GEN)

MLN Matters® Number: MM7499 Revised
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R993OTN

Related Change Request (CR) #: CR 7499
Effective Date: January 1, 2012
Implementation Date: January 3, 2012 for professional claims billed to carriers or B MACs; April 2, 2012 for institutional claims billed to Fiscal intermediaries or A MACs; October 9, 2012 for supplier claims submitted to DME MACs

Note: *This article was revised on November 7, 2011, to reflect changes made to CR7499. In this article, the implementation dates (see above), the CR release date, transmittal number, and the Web address for accessing CR7499 were revised. All other information is the same.*

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

Provider Action Needed
This article is based on Change Request (CR) 7499 which instructs Medicare's claims processing systems maintainers to replace the Health Insurance Claim (HIC) number being sent on the ASC X12 Transaction 835) with the Patient Control Number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background
The Centers for Medicare & Medicaid Services (CMS) generates *Health Insurance Portability and Accountability Act* (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR6870 and CR7068. The MLN Matters article corresponding to CR6870 can be reviewed at **http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf** and CR7068 can be reviewed at **http://www.cms.gov/transmittals/downloads/R812OTN.pdf** on the CMS website

It has been brought to the attention of CMS that providing the Patient Control Number as received on the original claim rather than the Health Insurance Claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR7499 instructs the shared systems to replace the HIC number being sent on the ERA with the Patient Control Number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear

in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: *Instructions in CR7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the Standard Paper Remit or the 004010A1 version of ASC X12 Transaction 835.*

Additional Information
The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R993OTN.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.

Update to Medicare Deductible, Coinsurance and Premium Rates for 2012 (MM7567) (GEN)

MLN Matters® Number: MM7567
Related CR Release Date: November 18, 2011
Related CR Transmittal #: R72GI

Related Change Request (CR) #: CR 7567
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

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 Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7567, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2012. Be sure billing staffs are aware of these updates.

Background
2012 Part A - Hospital Insurance (HI)
Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

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

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness. **The 2012 inpatient deductible is $1,156.00.** The coinsurance amounts are shown below in the following table:

Hospital Coinsurance		Skilled Nursing Facility Coinsurance
Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
$289.00	$578.00	$144.50

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The *Social Security Act* provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment

period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2012 Part A premiums are as follows:

Voluntary Enrollees Part A Premium Schedule for 2012	
Base Premium (BP)	$451.00 per month
Base Premium with 10% Surcharge	$496.10 per month
Base Premium with 45% Reduction	248.00 per month (for those who have 30-39 quarters of coverage)
Base Premium with 45% Reduction and 10% Surcharge	$272.80 per month

2012 Part B - Supplementary Medical Insurance (SMI)
Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

- Standard Premium: $99.90 a month
- Deductible: $140.00 a year
- Coinsurance: 20 percent

In addition, some beneficiaries may pay higher premiums based on their incomes. These amounts change each year. There may be a late-enrollment penalty.

Additional Information
The official instruction, CR7567, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R72GI.pdf** on the CMS website.

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

CMS News Flash (GEN)

A new fast fact was posted to the MLN Provider Compliance web page (**http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp**), which contains educational Fee For Service (FFS) provider materials to help you understand - and avoid - common billing errors and other improper activities identified through claim review programs. You can review quick tips on relevant provider compliance issues and corrective actions directly from this web page. Please bookmark this page and check back often as a new "fast fact" is added each month!

Are you short on time? The Centers for Medicare & Medicaid Services (CMS) has created podcasts from four popular ICD-10 National Provider Calls. These podcasts are perfect for use in the office, on the go in your car, or your portable media player or smart phone. Listen to all of the podcasts from a call or just the ones that fit your needs. To access the podcasts, visit the CMS Sponsored ICD-10 Teleconferences webpage located at **http://www.cms.gov/ICD10/Tel10/list.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

All providers and suppliers who enrolled in the Medicare program prior to March 25, 2011, will have their enrollment revalidated under new risk screening criteria required by the *Affordable Care Act* (section 6401a). Do NOT send in revalidated enrollment forms until you are notified to do so by your Medicare Administrative Contractor. You will receive a notice to revalidate between now and March 2013. For more information about provider revalidation, review MLN Matters® Special Edition Article SE1126, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf** on the Centers for Medicare & Medicaid Services website.

Hurry, time is running out! HIPAA Version 5010 and D.0 will be required to submit Medicare claims beginning Sunday, January 1, 2012! As of Sunday, January 1, 2012, Version 5010 and NCPDP D.0 will be required for all HIPAA standard transactions. Beginning Sunday, January 1, 2012, HIPAA Version 4010A1 will no longer be accepted by Medicare. All trading partners must operate in HIPAA Version 5010 and D.0. CMS strongly encourages providers to take advantage of the many resources available at

http://www.cms.gov/ICD10, **http://www.cms.gov/Versions5010andD0/01_overview.asp**, and **http://www.cms.gov/MFFS5010D0/** on our website. It is essential to begin the transition now to prevent a disruption to your claims processing and cash flow.

Looking for the latest Medicare Fee-For-Service (FFS) information? Then subscribe to a Medicare FFS Provider listserv that suits your needs! For information on how to register and start receiving the latest news, go to **http://www.cms.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to **http://www.cms.gov/MLNMattersArticles/downloads/What_Is_MLNMatters.pdf** and start receiving updates immediately!

The revised brochure titled "*The Medicare Appeals Process: Five Levels to Protect Providers, Physicians, and Other Suppliers*" (revised January 2011), is now available in downloadable format from the Medicare Learning Network® at **http://www.CMS.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf** on the Centers for Medicare & Medicaid Services website. This brochure is designed to provide an overview of the Medicare Part-A and Part-B administrative appeals process available to providers, physicians, and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process.

The Centers for Medicare & Medicaid Services (CMS) has released 4 podcasts and a video slideshow presentation of the May 18, 2011, national provider call on "CMS ICD-10 Conversion Activities, Including a Lab Case Study." The podcasts, slideshow presentation, and written transcripts are now available at **http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1246998** on the CMS website. The 4 audio podcasts with corresponding written transcripts, as well as the full written transcript of the call can be accessed by scrolling to the "Downloads" section at the bottom of the page. To access the video slideshow presentation, select the link in the "Related Links Outside CMS" section of the webpage.

The Centers for Medicare & Medicaid Services (CMS) has announced the expansion of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program to include the Round 2 and National Mail Order competitions. If you want to bid, you need to prepare now! You must make sure that your correspondence address and your authorized officials' names, Social Security numbers, and birth dates are accurate in your enrollment file at the National Supplier Clearinghouse (NSC) before registration starts. Before you submit a bid for a product category in a Competitive Bidding Area (CBA), you must have all required state licenses for that product category for each state in that CBA. It is VERY IMPORTANT that you make sure that current versions of all required licenses are in your enrollment file with the NSC BEFORE you bid. For more information about the Medicare DMEPOS Competitive Bidding Program please visit the CMS Competitive Bidding Web site at **http://www.cms.gov/DMEPOSCompetitiveBid/** on the CMS website.

The July 2011 issue of the "Medicare *Quarterly Provider Compliance Newsletter*" is now available in downloadable format from the Medicare Learning Network® at **http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903687.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. Please visit **http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf** to download, print, and search newsletters from previous quarters.

The Medicare Quarterly Provider Compliance Newsletter" is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. This publication is issued on a quarterly basis and highlights the "top" issues of that particular quarter. An archive and searchable index of current and previously-issued newsletters is available at **http://cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf** on the Centers for Medicare & Medicaid website.

The Office of Management and Budget recently approved changes to the Medicare Provider-Supplier Enrollment Applications (CMS-855) in order to update them from the 2008 versions, as well as the new CMS-855O application form used for the sole purpose of enrolling to order and refer items and/or services to Medicare beneficiaries. The revised and new forms are now available at **http://www.CMS.gov/CMSForms/CMSForms/list.asp?filtertype=dual&filtertype=keyword&keyword=855** on the Centers for Medicare & Medicaid Services (CMS) website. Providers and suppliers enrolling for the sole purpose to order and refer are required to begin using the new CMS-855O form immediately. Providers and suppliers using the other CMS-855 forms to enroll in Medicare are encouraged to begin using the revised forms, though the old forms may be used through October 2011.

Vaccinate Early to Protect Against the Flu /2011-2012 Influenza Vaccine Prices Are Now Available CDC recommends a y early flu vaccination as the most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Under Medicare Part B, Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And don't forget to immunize yourself and your staff. Get the Flu Vaccination - Not the Flu. CMS has posted t he 2 011-2012 s easonal i nfluenza vaccine p ayment l imits at : **http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp** on the CMS website. Influenza vaccine is NOT a Part D-covered drug. For information about Medicare's coverage of the influenza vaccine, its administration, and educational resources for healthcare professionals and their staff, visit **http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp** on the CMS website.

Several f act s heets t hat provide e ducation t o s pecific provider t ypes on how t o e nroll i n t he M edicare P rogram and m aintain t heir enrollment information using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) have been recently updated and a re a vailable i n do wnloadable f ormat f rom t he M edicare L earning Ne twork® (MLN). Please v isit **http://www.CMS.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf** for a c omplete l ist o f a ll M LN products r elated t o Medicare provider-supplier enrollment.

Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN® Educational Products electronic mailing list! For more information about the MLN® and how to register for this service, visit **http://www.cms.gov/MLNProducts/downloads/MLNProducts_listserv.pdf** and start receiving updates immediately!

Fee Schedule Updates (GEN)

The 2011 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) Web site, **http://www.medicarenhic.com/dme/dmfees.shtml**. This quarter the following notices have been posted:

- There are no updates to the 4th Quarter 2011 Jurisdiction A DME MAC Fee Schedule
- 4th Quarter 2011 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2011 Average Sales Price Medicare Part B Drug Pricing File - Revised
- 4th Quarter 2011 Oral Anticancer Drug Fees
- 3rd Quarter 2011 Oral Anticancer Drug Fees - Revised

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.

Quiz yourself and your staff

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

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/medicare-coverage-database/overview-and-quick-search.aspx

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LCD and Policy Article Revisions - Summary for October 14, 2011 (GEN)

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

Enteral Nutrition

LCD
Revision Effective Date: 08/02/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Refills information
DOCUMENTATION SECTION:
Added: Refills documentation information

Policy Article
Revision Effective Date: 08/02/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble Language
Removed: Documentation Language

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

LCD
Revision Effective Date: 10/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: ACHC as approved accreditation body for sleep labs

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

Power Mobility Devices - Prepayment Review Demonstration Project (MOB)

As announced by the Centers for Medicare & Medicaid Services (CMS) in a press release on November 15, 2011, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will begin conducting Phase 1 of the Medicare Prepayment Review and Prior Authorization of Power Mobility Devices demonstration project involving wide-spread prepayment review for power mobility devices (PMDs). Prepayment complex medical review will begin for claims with dates of service on or after January 1, 2012.

The demonstration project includes beneficiaries requiring a PMD and residing in:

California	New York
Florida	North Carolina
Illinois	Texas
Michigan	

The following PMDs will be subject to the demonstration:

- Group 1 Power Operated Vehicles (K0800-K0802 and K0812)
- All standard power wheelchairs (K0813 thru K0829)
- All Group 2 complex rehabilitative power wheelchairs (K0835 thru K0843)
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 thru K0855)
- Group 5 pediatric power wheelchairs (K0890 -K0891)
- Miscellaneous power wheelchairs (K0898)

CMS will hold Special Open Door Forums (ODF) via conference call to provide an opportunity for suppliers and physicians to ask questions about the demonstration. Teleconference information:

Suppliers - Friday, December 2 - 2:00 -3:30 pm Eastern Time
Dial: 1-866-501-5502
Conference ID: 29840167

Physicians - Monday, December 5 - 2:00 - 3:30 pm Eastern Time
Dial: 1-866-501-5502
Conference ID: 29845811

Note: For both calls, TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Participants may submit questions prior to the Special ODF to **pademo@cms.hhs.gov** by Thursday, December 1, 2011, 5pm ET. Also note:

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at **http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp** and will be accessible for downloading beginning on or around Tuesday, December 13, 2011.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit the CMS website at **http://www.cms.gov/opendoorforums/**.

To read more about the PMD demonstration visit the CMS website: **http://go.cms.gov/cert-demos**.

Additional educational information about the coverage, coding and documentation requirements for PMDs may be found on the NHIC Web site at: **http://www.medicarenhic.com/dme/**.

Reminder - Ultrasonic/Electronic Aerosol Generator With Small Volume Nebulizer - Coding Verification Review Requirement (SPE)

Recently it was brought to the attention of the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) that suppliers and pharmacies are billing code E0574 (ULTRASONIC/ELECTRONIC AEROSOL GENERATOR WITH SMALL VOLUME NEBULIZER). The article published by the DME MACs on November 4, 2010 titled "*Ultrasonic/Electronic Aerosol Generator with Small Volume Nebulizer - Coding Verification Review Requirement*" (see **https://www.dmepdac.com/resources/articles/2010/11_04_10.html**) required:

> *Effective for claims with dates of service on or after April 1, 2011, the only products which may be billed to Medicare using code E0574 (Ultrasonic/Electronic Aerosol Generator With Small Volume Nebulizer) are those for which a written coding verification has been made by the Pricing, Data Analysis, and Coding (PDAC) contractor and that are listed in the Product Classification Matrix of the DME Coding System (DMECS) maintained on the PDAC website,* ***https://www.dmepdac.com/dmecsapp/do/search***

Code E0574 and related accessories are reasonable and necessary to administer treprostinil inhalation solution (J7686) only. To date only one ultrasonic nebulizer has been approved to use code E0574 - Optineb-ir Model ON-100/7 (NebuTec, GmbH). There are no other nebulizers that are authorized to bill the DME MACs using code E0574. Suppliers billing for ultrasonic nebulizers not listed in the Product Classification Matrix of the DME Coding System (DMECS) must contact the PDAC for proper coding instructions.

With the exception of the Optineb-ir®, no other ultrasonic nebulizers have received approval to use code E0574 through the coding verification review process. Suppliers of ultrasonic nebulizers other than the Optineb-ir® who have incorrectly coded these items and had paid claims for E0574 with dates of service on or after April 1, 2011 should submit a voluntary refund. In addition, voluntary refunds should be submitted for paid claims for inhalation medications used in conjunction with an E0574 nebulizer.

The PDAC coding verification application required for these products is the DME and Supplies application. This application is located on the PDAC website here: **https://www.dmepdac.com/review/apps_check.html**. If you have questions please contact, the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website here: **http://www.dmepdac.com**. Once products are coded by the PDAC, they will be listed in the Product Classification Matrix on DMECS.

Results of Widespread Prepayment Probe for Lower Limb Prostheses (O&P)

Historical Review Results
This is the first DME MAC A Medical Review probe for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided. This probe was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

Current Review Results
The DME MAC Jurisdiction A has completed the prepayment probe review of claims for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided.

The review involved prepayment complex medical review of 102 claims submitted by 67 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 16 (16%) of the claims. For the remaining 86 claims, 10 claims were allowed and 76 were denied resulting in a claim denial rate of 88%. 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 86.6%.

Primary Reasons for Denial
Based on review of the documentation received, the following are the reasons for denial: Note that the percentages noted below reflect the fact that a claim could have more than one missing/incomplete item.

Lack of Medical Record Documentation

- 96% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 5.3% of the denied claims were missing the evaluation/assessment documentation for the functional level of item(s) billed (prosthetist assessment).

Clinical documentation did not support the functional level of the Lower Limb Prosthesis

- 4% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 1.3% of the denied claims were missing the proof of delivery.

Claim Examples
As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with Lower Limb Prostheses claims:

Example 1:
Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; Proof of delivery which validates that the beneficiary received the items that were billed; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item.
Missing: Clinician documentation to support functional level of device and to corroborate the prosthetist's records and the evaluation/assessment documentation for the functional level of item(s) billed.

Example 2:
Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item; and the evaluation/assessment documentation for the functional level of item(s) billed, which details the functional level of the items billed.
Missing: Clinical documentation to support functional level of device and to corroborate the prosthetist's records. Also missing was proof of delivery, which validates that the beneficiary received the items that were billed.

Example 3:
Received: The supplier submitted a detailed written order, which includes the beneficiaries name, specific items dispensed, treating physicians signature and date, and the start date of order; proof of delivery, validating that the beneficiary received the items that were billed; an invoice of the items, which includes the manufacturer, model numbers and cost of each item; and the prosthetist's evaluation/assessment documentation detailing the functional levels of items billed.
Missing: The submitted clinical documentation did not support the functional level of the device and did not corroborate the prosthetist's records. Since the prosthetist is a supplier, the prosthetist's records must be corroborated by the information in the medical record.

Next Step
Based on the results of this prepayment review, DME MAC A will continue to review claims for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided.

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

Educational References
NHIC provides extensive educational offerings related to the proper documentation requirements for Lower Limb Prostheses claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- **LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)**
- **The DME MAC Jurisdiction A Supplier Manual**
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements
- **Dear Physician Letter - Documentation of Artificial Limbs**
- **August 2011 CERT Errors**
- **CERT Physician Letter - Documentation**

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

Historical Review Results
DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of a previous prepayment probe review. The previous probe included claims reviewed from November 2010 through January 2011 and resulted in an 86.7% Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm). These findings include claims reviewed from April 01, 2011 through June 30, 2011.

The review involved prepayment complex medical review of 1,021 claims submitted by 203 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 255 (25%) of the claims. For the remaining 761 claims, 303 claims were allowed and 463 were denied resulting in a claim denial rate of 60.8%. 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 61.7%.

Primary Reasons for Denial
Based on review of the documentation received, the following are the primary reasons for denial which are listed from most common to least common:

Note that the percentages noted below reflect the fact that a claim could have more than one missing/incomplete item.

Lack of Clinical Documentation:

- 19% of the denied claims were missing clinical documentation to support LCD criteria for both the enteral nutrition and the enteral nutrition infusion pump (there was no clinical documentation submitted at all)
- 18% of the denied claims had insufficient clinical documentation to justify the LCD criteria needed for one or both of the following:
  - Enteral nutrition (Examples include documentation to support that the beneficiary has (a) permanent non-function or disease of the structures that normally permit food to reach the small bowel or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.) Note: The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.
  - Enteral infusion pump (Examples include documentation in the medical record to justify use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, gastrostomy/jejunostomy tube used for feeding).

Detailed Written Order issues:

- 4.3% of the denied claims had missing detailed written orders.
- 10.5% of the denied claims had an incomplete detailed written order.

DME MAC Informational Form (DIF) Discrepancies:

- 7.2% of the denied claims did not have the HCPCS code documented on the DIF.
- 11.8% of the denied claims had an incomplete or missing DIF.

Delivery Issues:

- 33% of the denied claims had missing delivery tickets, and missing items (such as the pump) from the delivery ticket
- 0.5% of the denied claims had missing beneficiary's names, dates, and signatures

Other Submission Issues:

- 3.8% were denied because of the illegibility of dates, signatures and medical records

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects these examples will assist suppliers in understanding the medical review process and the common documentation errors that occur with enteral nutrition claims:

Example 1:

Received: The supplier submitted a valid DIF and delivery ticket, and limited clinical documentation.
Missing: The detailed written physician's order was not submitted. There was insufficient documentation in the medical record to support coverage criteria for enteral nutrition and/or the enteral infusion pump per LCD L5041 requirements.

Example 2:

Received: The supplier submitted the following: A completed DIF and clinical documentation from the prescribing physician.
Missing: Delivery information is dated 02/24/2011 which is before the start date of the physician order. The order start date was 03/15/2011.

Example 3:

Received: A detailed written order from the physician and a completed DIF.
Missing: Delivery information does not show items billed (illegible). Missing progress notes to support the policy coverage criteria for enteral nutrition and the infusion pump per the LCD L5041. Proof of delivery is not valid, the enteral pump was not listed as an item delivered.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm).

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

Educational References:

NHIC provides extensive educational offerings related to the proper documentation requirements for enteral nutrition claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- **Enteral Nutrition (L5041) LCD**
- **Results of Widespread Prepayment Probe for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041)** (issued 03/11/2011)
- **DME MAC Jurisdiction A Supplier Manual** (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
- **CERT Physician Letter - Enteral Nutrition**
- **Enteral Nutrition Units of Service Calculator**
- **Frequently Asked Questions** (search word enteral)
- **Enteral Nutrition Supply Kits - Coverage Reminder**

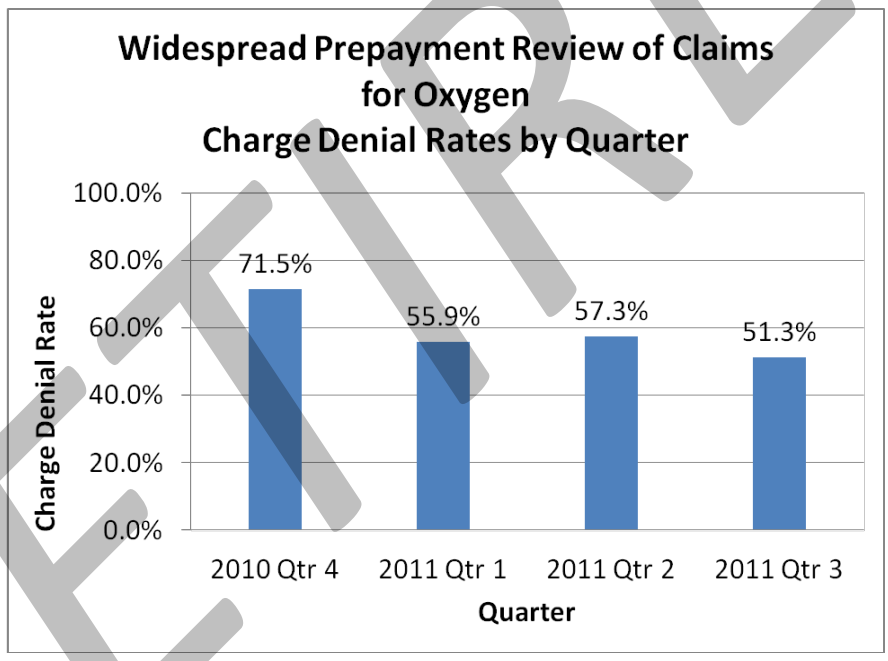
Results of Widespread Prepayment Review for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (OXY)

Historical Review Results
DME MAC A Medical Review continues to review Oxygen and Oxygen Equipment, based on the results of previous quarterly findings. The previous quarterly findings covered the period of April 01, 2011 through June 30, 2011 and resulted in a 57.3% Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim review dates primarily from July 01, 2011 through September 30, 2011.

The review involved prepayment complex medical review of 1,258 claims submitted by 377 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 427 (34%) of the claims. For the remaining 831 claims, 419 claims were allowed and 412 were denied resulting in a claim denial rate of 50.4%. 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 51.3%.

Charge Denial Rate Historical Data
The following graph depicts the Charge Denial rate from previous quarters to current;



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

Missing Documentation: Required Physician Visit per LCD L11468 (56.3%)

- 26.9% of the denied claims were missing treating physician visits - 30 days prior to the Initial CMN. (Initial issue of oxygen)
- 26.5% of the denied claims were missing treating physician visits both 30 days prior to the Initial CMN and within 90 days prior to the Recertification CMN. (Initial issue of oxygen)
- 2.9% of the denied claims were missing treating physician visits - 90 days prior to Recertification CMN. (Initial issue of oxygen)

Missing Documentation: Required CMN per LCD L11468 (5.3%)
In some cases Recertification CMNs were received but no initial CMN was received.

- 3.6% of the denied claims were missing the Initial CMN

- 1.7% of the denied claims were missing the Recertification CMN

Clinical Documentation Issues: Medical necessity could not be established (11.2%)

- 8.5% of the denied claims did not have documentation validating the oxygen saturation level listed on CMN.
- 2.7% of the denied claims had clinical documentation which did not support the use of home oxygen therapy. Examples:
  - Clinical notes do not include physician documentation of patient need for home oxygen therapy. Patient treatment is for use of hand held inhalers only.
  - Nocturnal testing received does not qualify patient for Group 1 guidelines (total of 5 minutes desaturation level of 88% or less). Lowest saturation level was recorded on CMN; however, total time did not meet the LCD criteria.
- 2.0% of the denied claims were due to miscellaneous issues. Examples:
  - Illegible documentation
  - Conflicting documentation: Example
    - Oxygen saturation testing dated in 2008, initial CMN dated 2010, and delivery ticket dated 2008.
  - Written orders only, no physician clinical visit
  - Additional Development Request (ADR) returned with no clinical documentation

Miscellaneous issues (2.5%)

- 1% of the denied claims had an invalid delivery ticket
- 1.5% of the denied claims; billing exceeds rental months covered (36 months)

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with Oxygen therapy claims.

Per LCD L11468 - Visit requirements

Patient must be seen and evaluated by treating physician within 30 days prior to the date of Initial Certification

For patients initially meeting Group 1, the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of any Recertification

Example 1: DOS 08/02/2011 codes billed: E0431- initial issue of Oxygen

Documentation received: Initial CMN, valid oxygen testing, valid delivery ticket, beneficiary authorization, and supplier generated home assessment check off sheet

Missing: Physician visit within 30 days prior to the Initial CMN dated 10/02/2010

Example 2: DOS 07/29/2011 codes billed: E1390 and E0431-initial issue of Oxygen

Documentation received: Physician written order, valid oxygen testing, Initial CMN, Recertification CMN, valid delivery ticket, supplier generated home initial assessment

Missing: Physician visit within 30 days prior to Initial CMN and physician visit within 90 days prior to Recertification CMN

Example 3: DOS 05/30/2011 codes billed: E0431 - initial issue of Oxygen

Documentation received: Physician written order, physician orders dated in 2009 and 2010, valid testing dated 10/29/08, Initial CMN, Re certification CMN, valid delivery ticket, ongoing physician clinical record dated 03/25/2011, supplier generated equipment assessment sheet

Missing: Physician clinical notes 30 days prior to initial CMN and within 90 days prior to Recertification CMN

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS E1390, E0431 and E0439.

Suppliers are reminded that repeated failure to respond to ADR requests could result in a referral to the Jurisdiction A Program Safeguard Contractor/Zone Program Integrity Contractor.

Educational References
NHIC provides extensive educational offerings related to the proper documentation requirements for E1390, E0431, and E0439 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements.

Suppliers are encouraged to review the following references:

- **The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)**
- The **DME MAC Jurisdiction A Supplier Manual**
  - "Welcome Page" provides valuable information to the CMS Web sites
  - Chapter 10 includes information regarding documentation requirements
- **January - August 2011 CERT Error articles**
- **CERT Physician Letter - Oxygen & Supplies**
- **Frequently Asked Questions** (search word oxygen)
- **Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439)** (November 5, 2010; Posted March 25, 2011; Posted June 17, 2011; Posted August 26, 2011).

Widespread Documentation Compliance Prepayment Review for Home Blood Glucose Monitors and Supplies (SPE)

NHIC, the DME MAC for Jurisdiction A, will be initiating a widespread prepayment review of claims for home blood glucose monitors and related supplies. This review is being initiated due to a high volume of claim errors found by the Comprehensive Error Rate Testing (CERT) Contractor.

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

The request will include the following:
1. Please submit a current order for the Glucose testing supplies, for the billed dates of service
2. Proof of beneficiary testing blood glucose (if billing quantities above the LCD limits)
3. Valid Proof of Delivery
4. A valid proof of request for refill of glucose testing supplies

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

A common finding in these reviews is missing or incomplete records. To ensure compliance, please submit the requested information within the timeframe requested.

Widespread Documentation Compliance Prepayment Review for Oxygen and Oxygen Equipment (OXY)

NHIC, the DME MAC for Jurisdiction A, will be initiating a widespread documentation compliance prepayment review of claims for Oxygen and Oxygen Equipment. This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) Contractor for missing and/or incomplete documentation.

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

The request will include the following:

1. A copy of the most recent Certificate of Medical Necessity (CMN) prior to the date of service
2. The treating physician's detailed written order for the DMEPOS item(s) (CMN can serve as detailed written order if sufficiently completed)
3. If the Date of Service (DOS) is prior to the signature date on the Detailed Written Order (DWO), proof of a dispensing order must be submitted
4. Copy of the beneficiary's most recent arterial blood gas PO2 and/or oxygen saturation test value reported on the CMN
5. Documentation of a physician office visit prior to the initial date of service: The Physician's office visit needs to be within 30 days prior to the initial CMN Date, 90 Days prior to the recert CMN date.
6. Valid Proof of Delivery

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

A common finding in these reviews is missing or incomplete records. To ensure compliance, please submit the requested information within the timeframe requested.

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.

Knowing Who to Contact for Your Inquiry - Outreach & Education or Customer Service (GEN)

The Jurisdiction A DME MAC Provider Outreach & Education Team has recently seen an increase in call volume related to inquiries that should instead be addressed by calling Customer Service or accessing the Interactive Voice Response (IVR) system. This article serves as a reminder of the types of inquires handled by each area.

Provider Outreach & Education
Provider Outreach & Education typically handles inquiries related to the following:

- Educational Seminars/Workshops/Online Training/Teleconferences
- Educational Materials/Publications/Web site
- Ask-the-Contractor Teleconferences (ACTs)
- Provider Outreach & Education (POE) Advisory Group
- Complex/Global Issues (requiring education)

The Outreach & Education Team can be reached by calling: **781-741-3950**

Note: *The Provider Outreach & Education Team does not handle any claim related inquiries. You must contact Customer Service for all claim related inquiries.*

Interactive Voice Response (IVR) System
The Centers for Medicare & Medicaid Services (CMS) requires that Medicare contractors offer self-service options to their providers for general inquiries. CMS also requires providers to utilize those self-service options such as the IVR application.

Providers can obtain information such as claim status, patient eligibility, Certificate of Medical Necessity (CMN) status information, pricing and appeals information, as well as some general information. Our Customer Service Representatives continue to be available to serve the provider community with more complex inquiries.

The IVR is maintained on a separate line from our Customer Service Representatives and is available beyond the normal hours of operation of the Customer Service Contact Center. As a result, providers have greater access to the information that is needed.

Note: *Based on the CMS requirements, if a provider contacts a Customer Service Representative with a question that can be handled by the IVR, the provider will be referred back to the IVR.*

The IVR can be reached by calling: **866-419-9458**

Hours of Availability:

- Monday - Friday 6:00 a.m. - 7:00 p.m. EST *
- Saturday 6:00 a.m. - 3:00 p.m. EST *

** These hours represent the general hours of availability for access to all menu options. The IVR is available 24 hours a day, 7 days a week. Menu options that require system access (e.g., CWF) are limited to that systems availability. The IVR is not available during system upgrades or routine maintenance.*

Customer Service
Customer Service Representatives are available to answer general questions, as well as, difficult, claim specific questions. They are also available to assist you in using the IVR and to request a telephone re-opening for certain claim denials. Customer Service uses a three-tiered approach for answering supplier telephone inquiries. This tiered structure is designed to improve accuracy, completeness, consistency and timeliness by ensuring that staff with the appropriate level of expertise address supplier issues.

Level 1 CSR

- First level CSRs shall answer a wide range of basic questions that cannot be answered by the IVR or other interactive self-service technology.
- At a minimum, first level CSRs shall handle questions that do not require substantial research and easily can be answered during the initial call. Contractors determine what types of inquiries are best answered by first level CSRs.
- Some examples of this level of inquiry may include:

1. Eligibility, claims status or Medicare secondary payer (MSP) status inquiries not adequately handled by the IVR
2. Straight-forward claim denial questions that cannot be handled by the IVR
3. Questions with well-documented, nationally consistent and easily accessible answers

First level CSRs have the authority to refer more complex questions to second level CSRs.

Level 2 CSR

- Second level CSRs have more experience and expertise enabling them to answer more complex questions. These questions may include:
  1. Telephone inquiries concerning local coverage determinations not requiring a referral to medical review
  2. Dissatisfied callers who require a higher level of service
- Second level CSRs may serve as consultant subject matter experts for first level CSRs and, therefore, do not always have to speak directly to a provider.
- Inquiries that require additional time or a yet higher degree of expertise and/or research shall be referred to the Provider Relations Research Specialists (PRRS).

Level 3 Provider Relations Research Specialists (PRRS)

- The PRRS responds to the more complex provider questions including those related to coverage, coding, and payment policy.
- The PRRS receives its workload through referrals from the tiered process described above and though a similar process from Written Inquiries.
- The PRRS will refer global education topics to the Outreach and Education department as appropriate.
- The PRRS must provide clear and accurate written answers within 45 business days of receipt.

Note: *Suppliers should be advised that any inquiry that can be resolved by accessing the Interactive Voice Response (IVR) system will result in being referred back to the IVR for assistance. Customer Service cannot address information that is provided via the IVR system.*

A Customer Service Representative can be reached by calling: **866-590-6731**

Hours of Availability:

- Monday - Friday 8:00 a.m. until 5:00 p.m. EST with the exception of Fridays from 2:30 p.m. until 4:30 p.m. EST due to call center training. The DME MAC A IVR will continue to be available during these training times. The Call Center is also closed for select holidays.

Join DME MAC A for Our Quarterly ACT/Webinar - Updates/Open Q&A (GEN)

Date: Tuesday, December 20, 2011
Time: 1:00 PM - 2:30 PM Eastern Time

Call Details

During this call, the Provider Outreach & Education Team will provide a brief update followed by an operator assisted question and answer period. The call will begin promptly at 1:00 PM ET and may last up to one hour and thirty minutes.

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

Registration

To participate, webinar registration is **required**. After your registration is complete, you will receive a confirmation e mail with instructions on how to join the Webinar and teleconference. **Please retain your email confirmation** because you will not be able to access the ACT webinar without it.

System Requirements

PC-based Attendees

Required: Windows® 7, Vista, XP or 2003 Server

Macintosh®-based Attendees

Required: Mac OS® X 10.4.11 (Tiger®) or newer

Space is Limited

Reserve your Webinar seat now at **https://www2.gotomeeting.com/register/438515538**

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

Ask-the-Contractor Teleconference (ACT) Q&A - September 13, 2011 (GEN)

Note: *This document was revised on November 04, 2011 adding questions 30, 31, and 32.*

The DME MAC Jurisdiction A quarterly ACT call was conducted Tuesday, September 13, 2011 as a teleconference/webinar and was based on recent updates and hot topics. A brief presentation was provided followed by an operator assisted Q&A session.

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

Q1: How far back can a sleep study go and still be considered acceptable for Medicare?

A1: There is nothing regulated that addresses a time limit or expiration with regard to the "age" of the sleep test; however, coverage of a PAP device for the treatment of OSA is limited to claims where the diagnosis of OSA is based upon a sleep test that meets the Medicare coverage criteria in effect for the date of service of the claim for the PAP device. The sleep test must be either a polysomnogram performed in a facility-based laboratory or a home sleep test. The test must be ordered by the beneficiary's treating physician and conducted by an entity that qualifies as a Medicare provider of sleep tests and is in compliance with all applicable state regulatory requirements.

Q2: Does the National Supplier Clearinghouse (NSC) send re-enrollment reminder letters to suppliers whose existing enrollments are about to expire?

A2: Yes. CMS requires that all DMEPOS suppliers with Medicare billing privileges re-enroll with the Medicare program every three years through the National Supplier Clearinghouse (NSC). Suppliers will receive a letter from the NSC instructing them to revalidate (formerly re-enroll) for billing privileges using the Internet-based PECOS system. Upon receipt of the revalidation letter, suppliers are required to go online and respond to the request within 30 days. If the NSC does not receive the completed revalidation packet, the supplier's billing privileges are subject to normal filing rules including revocation or inactivation. For additional information, refer to the NSC Web site at: **http://www.palmettogba.com/nsc**

Q3: Is there a user-friendly Site Map on the DME MAC A Web site for easier online navigation?

A3: Yes. The Site Map is available on each Web site page. You can access it by scrolling to the bottom of the page where you will see About NHIC, Site Map, Privacy Policy and Contact Us.

Q4: How are you educating the Physicians that they are required to document in their notes the justification for equipment?

A4: DME MAC A doesn't typically educate ordering physicians; however, the Medical Directors of each DME MAC Jurisdiction have created several Dear Physician letters to assist suppliers in educating physicians on the importance of providing complete and accurate proper documentation to support services they order for their Medicare beneficiaries. These letters are available on the DME MAC Web site at: **http://www.medicarenhic.com/dme/phy_letters.shtml**

Q5: What are the new requirements regarding refills for DMEPOS items and supplies provided on a recurring basis?

A5: For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

Q6: What is the timeframe for the contractor to complete a reopening request?

A6: The contractor shall complete the reopening action within 60 days from the date of receipt of the party's reopening request.

Q7: What are the requirements for documenting ongoing or continued use?

A7: For many items, Medicare coverage requires that continued use must be assessed and documented by the treating physician. Rental items such as oxygen, nebulizers, CPAP, wheelchairs, and hospital beds and recurring supplies such as glucose test strips, urological supplies, and ostomy supplies must be periodically justified in the medical record. Ongoing need for and use of the item must be documented in the patient's record in order for Medicare to continue reimbursement for the equipment or supplies. In these instances, the physician or their staff should regularly review the use of medical equipment and supplies by their patients. This review should be no different than your review of the continued need for medication or other treatments. There is no regulated "specific" time frame; however, if a serviced is being provided monthly then there needs to be medical evidence to support the monthly continuous need.

Q8: Is there a Local Coverage Determination (LCD) for wrist splint supports?

A8: No. Currently, there is no national or local policy for wrist splint supports. The DME MACs and ZPICs have the authority to review any claim even if there is no formal national or local policy. In those situations, the contractor first determines whether the item falls within a statutory benefit category that is within its jurisdiction. If it is, then the reviewer determines whether the item is reasonable and necessary for the particular patient. To do so, it may be necessary to conduct a review of pertinent medical literature. It also includes review of detailed documentation from the ordering physician and supplier supporting the medical necessity of the item in the individual case.

Q9: Once a capped rental is owned by a beneficiary and it is in need of repair, is the beneficiary responsible for the cost?

A9: Payment is allowed for reasonable and necessary repairs or nonroutine service of beneficiary-owned DMEPOS if not otherwise covered under an equipment warranty.

Q10: Please explain the use of the RA and RB modifiers.

A10: The RA modifier is used for replacement of the complete item due to reasonable useful lifetime or to accidental damage, theft, or loss. If a new item were provided due to a change in condition, it would be a different item, billed with a different HCPCS code, not a "replacement" of the original item. The RA modifier would not be used in this situation. The RB modifier is used to indicate replacement of a part of DME furnished as part of a repair for claims with dates of service on or after January 01, 2009.

Q11: What is acceptable proof that we attempted to get a signature on a proof of delivery?

A11: Suppliers may deliver directly to the beneficiary or the designee. An example of proof of delivery to a beneficiary is having a signed delivery slip, and it is recommended that the delivery slip include: 1) The patient's name; 2) The quantity delivered; 3) A detailed description of the item being delivered; 4) The brand name; and 5) The serial number. If the supplier utilizes a shipping service or mail order, an example of proof of delivery would include the delivery service's tracking slip and the supplier's own shipping invoice. If possible, the supplier's records should also include the delivery service's package identification number for that package sent to the beneficiary. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and if possible, the date delivered. If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim. Suppliers may also utilize a return, postage-paid delivery invoice from the beneficiary or designee as a form of proof of delivery. The descriptive information

concerning the DMEPOS item (i.e., the patient's name, the quantity, detailed description, brand name, and serial number) as well as the required signatures from either the beneficiary or the beneficiary's designee should be included on this invoice as well.

Q12: If the patient maliciously damages their group 2 power chair during the rental period, is the supplier responsible for fixing the chair at no cost to the patient or can an ABN be obtained for patient abuse?

A12: There can be no payment for the repair of rented items under any circumstances. Reimbursement for repairs is included in the rental payments. An ABN is not applicable in this situation.

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

Q13: If an item is associated with the KX modifier but we have not obtained supporting medical necessity documentation up front from the MD, is it still acceptable to affix the KX modifier to a claim?

A13: If you have not seen or received evidence directly related to the specific Local Coverage Determination (LCD) medical necessity criteria then you should not add the KX modifier to the line item during claim submission.

Q14: Is NHIC going to be one of the contractors conducting electronic reopenings in October?

A14: DME MAC A will not be offering this electronic capability in October; however, it is something that we are considering for a future enhancement.

Q15: Is the implementation date for the PWK segment still October 03, 2011?

A15: CMS delayed the implementation of the PWK (paperwork) segment associated with the X12N Version 5010 837 Professional and Institutional electronic claim transaction originally scheduled for July and October 2011. This means Medicare billers will continue to submit additional documentation which is needed for claims adjudication following the existing process established by their Medicare claims administration contractor.

CMS will give Medicare billers ample notice before implementing change requests (CR) 7041 and 7306, which change how additional documentation for claims adjudication is submitted. For additional information related to CR7041 and CR7306, please refer to the MLN Matters articles associated with these CRs:

http://www.CMS.gov/MLNMattersArticles/downloads/MM7041.pdf
http://www.CMS.gov/MLNMattersArticles/downloads/MM7306.pdf

Q16: Does Medicare cover repairs to patient neglected rented equipment?

A16: There can be no payment for the repair of rented items under any circumstances. Reimbursement for repairs is included in the rental payments. An ABN is not applicable in this situation. However, if you believe that the said repair is required because of malicious damage or culpable neglect by the beneficiary, you can present the information to the DME MAC for investigation. If the DME MAC, in consultation with the CMS, agrees that the beneficiary is responsible for the damage, the supplier can charge the beneficiary.

Q17: Can we get a written order for a glucose meter to also include all the related supplies?

A17: The order must specifically list all items which are separately billed. This is to include the base item and all related accessories and supplies.

Q18: Can an order for diabetic supplies be good for lifetime?

A18: Yes. However, a new order is required in the following situations:

- There is a change in the order for the accessory, supply, drug, etc.;
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy;

- When an item is replaced; and
- When there is a change in the supplier

Q19: Does every page of a medical record entry need to be signed?

A19: Yes. Medicare requires that healthcare providers ordering or documenting the medical necessity for items or services received by Medicare beneficiaries must be identifiable. Medical record authorship is generally accomplished through a handwritten or electronic signature (signature stamps are not acceptable).

If the medical record or entry omits a legible identifier, the author is required to attest to the authenticity of the record. For an overview of the key points of CMS' signature requirements, including signature logs and attestation statements, refer to MLN Matters article MM6698 at: **http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf**

Q20: Where can one locate the 2011 Annual SNF Consolidated Billing HCPCS File?

A20: **http://www.cms.gov/SNFConsolidatedBilling/71_2011Update.asp**

Q21: Must the detailed written order include a HCPCS code?

A21: No. However, a description of the item is required. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number.

Q22: What are the necessary elements for proof of delivery when a shipping service is utilized?

A22: If the supplier utilizes a shipping service or mail order, an example of proof of delivery would include the service's tracking slip, and the supplier's own shipping invoice. If possible, the supplier's records should also include the delivery service's package identification number for that package sent to the beneficiary. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and if possible, the date delivered. If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the date of service on the claim.

Q23: Why is an ABN needed when a product is never covered by Medicare such as the fully electric bed E0265?

A23: Although a fully electric hospital bed is never covered, other hospital beds still fall under a Medicare benefit. Therefore, if you bill without an ABN, the claim will deny with a contractual obligation (CO).

Q24: Do we need to keep medical records onsite, or can we request them as needed?

A24: That is a business decision based on your companies needs; however, in the event of a claim review/audit, you must have access to the specified records.

Q25: Does a supplier need to have all pertinent medical record documentation on hand prior to submitting a claim?

A25: In order to submit a claim to Medicare you are required to have a detailed written order on file. It is recommended that you also collect as much supporting documentation evidence up front as possible. However, there is no requirement that mandates that you collect the documentation up front.

Q26: If replacing an item for a flood victim, is the RA modifier needed on the claim line for the replacement?

A26: Yes. The RA modifier is needed on the claim. In addition, you must submit narrative language that addressed the reason for the replacement.

Q27: Equipment was damaged during hurricane Irene. Will Medicare begin a new capped rental for replacement equipment since the previous equipment is not repairable?

A27: Yes. Since the replacement is a result of a natural disaster, Medicare will consider beginning a new capped rental on medically necessary equipment.

Q28: Can you please explain a "blanket" ABN?

A28: A notifier should not give an ABN to a beneficiary unless the notifier has some genuine doubt regarding the likelihood of Medicare payment as evidenced by its stated reasons. Giving ABNs for all claims or items or services (i.e., "blanket ABNs") is not an acceptable practice. Notice must be given to a beneficiary on the basis of a genuine judgment about the likelihood of Medicare payment for that individual's claim.

Q29: Can an ABN be obtained for a non-compliant CPAP patient?

A29: The supplier may, after day 60 following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not yet met the policy criteria for continued coverage. This ABN should advise the beneficiary that if, by the 90th day of therapy, they do not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face to face evaluation), Medicare may deny their subsequent claim(s) and that the beneficiary will be liable for payment.

Q30: Can an ABN be provided in situations where documentation cannot be obtained from the physician?

A30: If you simply have not obtained the medical documentation or are unsure of its contents, this is not an acceptable reason to obtain an ABN. An ABN received "just in case" the documentation does not support the medical need is considered a generic ABN and is not acceptable evidence of Advance Beneficiary Notification. If you have obtained all medical documentation and it is not sufficient to support the medical need based on the LCD, a properly executed ABN would be appropriate. The supplier will be held liable unless an ABN has been properly executed.

Q31: Can an ABN be provided in situations where documentation is obtained by the physician but doesn't meet the requirements, such as no face-to-face evaluation for a PAP patient or the face-to-face evaluation is incomplete for a PAP patient?

A31: Yes. If the patient's medical record does not adequately support the medical need for the item, the supplier will be held liable unless an ABN has been properly executed.

Q32: Is an oxygen saturation test performed by a skilled nursing facility (SNF) acceptable to meet the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) policy criteria?

A32: The qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test (i.e., Part A provider, laboratory, Independent Diagnostic Testing Facility (IDTF), or a physician). If the entity doing the test complies with these standards then the test would be acceptable to meet the oxygen policy requirements. If the test, tester and/or the test site does not qualify as an entity being able to bill for the test then the test is not acceptable and therefore will not meet the policy requirements.

ListServe Subscription - What is it and who should register? (GEN)

The DME MAC A ListServe subscriptions serve as an electronic communication mechanism between the Jurisdiction A DME MAC contractor and our supplier community, which is used to notify subscribers of important and time sensitive Medicare program information. Only Internet access and a valid email address are necessary to join. Subscribers gain immediate access to latest Medicare news, claim filing issues, policy changes as well as updates related to the following:

- Medicare publications (newsletters, articles, supplier manual updates, etc.)
- Educational training event offerings
- Urgent CMS announcements

Who should register?
In order to get the most out of these electronic mailing lists, the Jurisdiction A DME MAC recommends that **all individuals who have a role in claim submission be registered**. **This includes all durable medical equipment, prosthetic, orthotic, and supply company owners, company compliance officers, office managers, billing staff, etc.**

The following specialty/area of interest ListServes enable DME MAC A to send targeted information to specific supplier/provider audiences:

- DME General Interest
- Drug Coverage
- Electronic Data Interchange
- Frequently Asked Questions (FAQs)
- Medical Review/LCDs
- Medicare Remit Easy Print (MREP)
- Mobility/Support Surfaces
- Oxygen
- Parenteral/Enteral Nutrition (PEN)
- Prosthetics & Orthotics
- Specialty Items
- Supplier Manual
- Supplier Training & Event News
- Vision

To register for the above ListServe topics visit: **http://www.medicarenhic.com/dme/listserve.html**

Prospective Billing for Parenteral and Enteral Nutrition (PEN)

This article serves as clarification for the proper billing of Enteral and Parenteral Nutrition claims prospectively to ensure proper claim payments. Per **Change Request 7452**:

> *"For DMEPOS items and supplies that are provided on a recurring basis, billing must be based on prospective, not retrospective use. The following scenarios are illustrative of this concept:*
>
> *Scenario 1: The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order, delivers 100 units and bills the claim with a date of service as the date of delivery indicating 100 units. This is an example of prospective billing and is acceptable.*
>
> *Scenario 2: The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order and delivers 100 units. A claim is not billed. At the end of the month, the supplier determines that the beneficiary used 90 units for the month and delivers 90 units to replace the nutrient used. A claim is then submitted with a date of service as the date of delivery indicating 90 units of enteral nutrition. This is an example of retrospective billing and is not acceptable."*

The following instructions apply to enteral and parenteral nutrition claims:

No more than one month's supply of parenteral/enteral nutrients (PEN), equipment, or supplies may be dispensed at one time. Therefore, the maximum supply that can be billed at one time is a 31-day supply.

Suppliers must not automatically dispense a quantity of items on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. It is the supplier's responsibility to assess how much nutrition and supplies the beneficiary is actually using by contacting the beneficiary or caregiver prior to dispensing the items. The supplier must determine the quantities that remain from the previous delivery and modify the quantity delivered or the delivery date accordingly. If the beneficiary has not used all of their previously delivered nutrients/supplies, the supplier should either delay delivery of the next shipment or should reduce the quantity delivered so that there is no more than one month's supply on hand at any one time. This may occur in situations in which the beneficiary was admitted to the hospital, or in which the beneficiary did not receive their usual nutrient intake because of an acute illness, etc.

Contact with the beneficiary or designee regarding refills should take place no sooner than approximately 14 days prior to the delivery/shipping date. For subsequent refill deliveries, the supplier should deliver the product no sooner than 10 days prior to the end of

usage for the current product. The Medicare system will allow up to a 10-day overlap in dates of service for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply. **Reminder:** Claims should not be consistently 10 days earlier each month as this would allow for additional payments.

The supplier itself may deliver the parenteral/enteral nutrition and supplies directly to the beneficiary or the supplier may use a shipping service to ship the items. If the supplier delivers the items directly to the beneficiary, the "From" date of service on the claim will be the actual date the items were delivered. If the supplier ships the items to the beneficiary using a shipping service, the "From" date of service will be the date the items were shipped. To determine the "To" date of service, the supplier counts the number of days the nutrients are expected to last (example: supplier ships a 28-day supply) and adds that number of days to the "From" date on the claim. **Span dates on the claim will not usually match the dates of expected use of the nutrients.**

Example: Supplier used a shipping service
Month 1

- 08/04/2011: 28-day supply shipped
- 08/06/2011: Beneficiary receives supply of nutrients
- 08/07/2011: Beneficiary starts using nutrients
- 09/04/2011: Beneficiary finishes supply of nutrients in this shipment
- Dates of service on claim:
    - From date = 08/04/2011 (date the nutrients were shipped)
    - To date = 08/31/2011 (28 days after the from date since a 28-day supply was shipped)

Note: *The span dates ("From" and "To" dates) are determined by the date the nutrients were shipped and the number of days for which the quantity shipped is expected to last. The span dates **do not** coincide with the dates the beneficiary actually used the nutrients.*

Month 2

- 08/26/2011: Supplier calls beneficiary to determine beneficiary's usage during the previous month and determines quantity of next shipment
- 08/30/2011: 28-day supply of nutrients shipped to beneficiary (expected dates of use 09/05/2011 - 10/02/2011)
- 09/02/2011: Beneficiary receives shipment
- 09/05/2011: Beneficiary begins using nutrients shipped
- 09/13/2011 - 09/20/2011: Beneficiary admitted to inpatient hospital stay
- 10/09/2011: Beneficiary exhausts supply
- Dates of service on claim:
    - From date = 08/30/2011 (date the nutrients were shipped)
    - To date = 09/26/2011 (28 days after the "From" date since a 28-day supply was shipped)

Note: *The next month's shipment should be delayed to account for the additional supplies on hand due to the inpatient hospital stay.*

Shipping Supply Kits
Supply kits consist of multiple items which are sometimes shipped separately. As with nutrients, the span dates on the claim usually will not match the dates of expected use of the supplies.

Example: Supplier uses a shipping service

- 08/01/2011: 28-day supply of infusion pump bags and tubing shipped
- 08/08/2011: 28-day supply of irrigation syringes shipped
- 08/26/2011: 28-day supply of infusion pump bags and tubing shipped

Claim submission based upon above shipping example:
Month 1

- HCPCS = B4035
- Units of service = 28 UOS
- From date = 08/01/2011
- To date = 08/28/2011

Month 2

- HCPCS = B4035
- Units of service = 28 UOS
- From date = 08/26/2011
- To date = 09/23/2011

In instances where the supplies are delivered directly by the supplier, **the date the beneficiary received the DMEPOS supply shall be the "From" date on the claim.**

If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the "From" date on the claim.

Please see the following **Self-Service Tools** that will assist in filing PEN claims:

- Supply Refill and Contact Calculator
- Enteral Nutrition Units of Service Calculator

Reminder: Start Using the Revised CMS-855S Enrollment Application (GEN)

DMEPOS suppliers are reminded that the CMS-855S enrollment application was recently revised to capture additional information pertinent for enrollment processing. Suppliers should use the CMS-855S version (07/11) if enrolling in Medicare for the first time, reporting changes to existing enrollment, if you have been asked to revalidate your existing enrollment, and other limited circumstances.

The 07/09 version of the CMS-855S will only be accepted through **December 31, 2011**. Any information received on the obsolete form after this point will be returned to the supplier resulting in a delay to your enrollment activities.

Download and begin using the revised version today by accessing the CMS Forms section of the CMS Web site at **http://www.cms.gov/CMSForms/CMSForms/**

Revised Advanced Beneficiary Notice of Noncoverage (ABN) Required for Use on January 01, 2012 (GEN)

Note: *This article was revised on October 14, 2011 to note the change of date for the required use of the new form from November 01, 2011 to January 01, 2012.*

The Revised Advanced Beneficiary Notice of Noncoverage (ABN), FORM CMS-R-131, is now available and required for use on January 01, 2012.

ABNs are effective as of the OMB approval date given at the bottom of each notice. The routine approval is for 3-year use. Notifiers are expected to exclusively employ the effective version of the ABN. CMS will allow a 6-month transition period from the date of issuance of these instructions for mandatory use of the revised ABN.

The latest version of the ABN (with the release date of **3/2011** printed in the lower left hand corner) is now available for immediate use.

Notifiers are required to use the revised ABN beginning **January 01, 2012**.

The revised ABN and instructions are available at: **http://www.cms.gov/BNI/02_ABN.asp**

Third Quarter 2011 - 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 July through September 2011 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	157,216	The procedure code, modifier, or procedure code and modifier combination is invalid.
C054 - Invalid National Provider Identifier (NPI) check	120,372	The referring provider NPI number has an invalid check digit.
C044 - Subscriber Primary ID Invalid	37,497	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C171 - Capped Rental - Modifier Missing	28,648	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.
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	23,178	The Tax ID (Employer Identification Number/Social Security Number) that was submitted does not match what is on file with the NPPES or the National Supplier Clearinghouse (NSC).
C003 - Billing NPI Not Found on Crosswalk	20,799	There is no link between the NPI that was submitted and a PTAN/NSC.
B108 - Billing provider not authorized for submitter	19,526	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C095 - Diagnosis Code Invalid - Pointer 1	19,231	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
A051 - Subscriber postal ZIP code is invalid	14,609	The subscriber's ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
C179 - Service From/To Dates Not Equal	14,043	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.

Third Quarter 2011 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the third quarter of 2011. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed; however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from July through September 2011.

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.	37,900
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.	9,895
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.	2,507
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).	2,243
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.	2,229
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.	1,640
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid ordering provider primary identifier.	**Item 17B** - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician.	941
CO 16 N51 Electronic interchange agreement not on file for provider/submitter.	The PTAN/NSC on file is not eligible to submit electronic claims.	876
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.	625
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).	553

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 charts and share it with your colleagues.

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 December of 2011 chapters 1, 2, 4, 8, 9, 10 and 12 of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

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.

MLN Special Edition Article #SE1126
"*Further Details on the Revalidation of Provider Enrollment Information*"
http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf
Do NOT submit your revalidation until you are notified to do so by your MAC. You will receive a notice to revalidate between now and March 2015.

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**

2012 Jurisdiction A DME MAC Holiday Schedule (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) will be observing the following holidays in 2012:

Holiday	2012 NHIC Holiday Schedule
New Year's Day	Monday January 2
Martin Luther King, Jr. Day	Monday January 16
Memorial Day	Monday May 28
Independence Day	Wednesday July 4
Labor Day	Monday September 3
Veteran's Day	Monday November 12
Thanksgiving Day	Thursday November 22
Friday following Thanksgiving	Friday November 23
Company-designated Floating Holiday	Monday December 24
Christmas Day	Tuesday December 25

DME MAC A's Gift Policy (GEN)

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

For Your Notes

Join the NHIC, Corp. DME MAC A ListServe!

Visit **http://www.medicarenhic.com/dme/listserve.html** today!

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:
C2C Solutions, Inc.
Attn: QIC DME
P.O. Box 44013
Jacksonville, FL 32231-4013

Faxed Reopenings: 781-741-3914

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

Reconsideration Street Address for Overnight Mailings:
C2C Solutions, Inc.
Attn: QIC DME
532 Riverside Avenue 6 Tower
Jacksonville, FL 32202

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:

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

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Mailing Address:

Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:

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

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

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

DME MAC Jurisdiction A Resource

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

December 2011
Number 22

Publication Information

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

Visit the following websites for more information:

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

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

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

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