DME MAC Jurisdiction A Resource

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

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Billing/Finance

General Information

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

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Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (MM7369) (GEN)

MLN Matters® Number: MM7369
Related CR Release Date: May 6, 2011
Related CR Transmittal #: R2213CP
Related Change Request (CR) #: 7369
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

Provider Action Needed
Change Request (CR) 7369, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs) that are effective on July 1, 2011 for Medicare. Be sure your billing staff is aware of these changes.

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

Both code lists are posted at **http://www.wpc-edi.com/Codes** on the Washington Publishing Company (WPC) website. The lists at the end of this article summarize the latest changes to these code lists, as announced in CR7369.

Additional Information
To see the official instruction (CR7369) issued to your Medicare Carrier, RHHI, DME MAC, FI and/or MAC, refer to **http://www.cms.gov/Transmittals/downloads/R2213CP.pdf** on the CMS website. If you have questions, please contact your Medicare Carrier, RHHI, DME MAC, FI and/or MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

CR7369 Changes

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	1/30/2011

Modified Codes - CARC:
None

Deactivated Codes - CARC:
None

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N542	Missing income verification	No
N543	Incomplete/invalid income verification	No

Modified Codes - RARC:

Code	Modified Narrative	Medicare Initiated
M37	Not covered when the patient is under age 35.	No
M116	Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program.	No
N62	Dates of service span multiple rate periods. Resubmit separate claims.	No
N356	Not covered when performed with, or subsequent to, a non-covered service.	No
N383	Not covered when deemed cosmetic.	No
N410	Not covered unless the prescription changes.	No
N428	Not covered when performed in this place of service.	No
N429	Not covered when considered routine.	No
N431	Not covered with this procedure.	No

Deactivated Codes - RARC:
None

Claim Status Category Code and Claim Status Code Update (MM7348) (GEN)

MLN Matters® Number: MM7348
Related CR Release Date: March 18, 2011
Related CR Transmittal #: R2177CP
Related Change Request (CR) #: 7348
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

What You Need to Know
This article, based on CR7348, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 will be updated during the June 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting will be posted at **http://www.wpc-edi.com/content/view/180/223/** on or about July 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on July 5, 2011.

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

Additional Information
The official instruction, CR7348 issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2177CP.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.

Emergency Update to the CY 2011 Medicare Physician Fee Schedule Database (MM7300) (GEN)

MLN Matters® Number: MM7300 Revised
Related CR Release Date: January 7, 2010
Related CR Transmittal #: R833OTN

Related Change Request (CR) #:7300
Effective Date: January 1, 2011
Implementation Date: No later than January 14, 2011

Note: *This article was revised on March 20, 2011, to reflect a new CR. That CR corrected the implementation date. The transmittal number, release date and web address of the CR was also changed. All other information remains the same.*

Provider Types Affected
This article is for physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed
This article is based on Change Request (CR) 7300, which amends payment files that were issued to Medicare contractors based on the 2011 MPFS Final Rule. This CR also reinstates three Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) HCPCS L-codes, as described below. Be sure your billing staff is aware of these changes.

Background
Payment files were issued based upon the Calendar Year (CY) 2011 MPFS Final Rule, issued on November 2, 2010, and published in the "Federal Register" on November 29, 2010. CR 7300 amends those payment files to include MPFS policy and payment indicator revisions described in the CY 2011 MPFS Final Rule Correction Notice, issued in December 30, 2010, (**http://www.ofr.gov/(X(1)S(zj23h5e5vs3xn5y2yjsecx03))/inspection.aspx?AspxAutoDetectCookieSupport=1**) to be published in the "Federal Register" on January 11, 2011, as well as relevant statutory changes applicable January 1, 2011. Therefore, new MPFS payment files have been created and are available. CR 7300 also reinstates three DMEPOS Healthcare Common Procedure Coding System (HCPCS) L-codes. Following is a summary of the changes as they impact providers:

Medicare Physician Fee Schedule Revisions and Updates
Some physician work, Practice Expense (PE) and Malpractice (MP) Relative Value Units (RVUs) published in the CY 2011 MPFS Final Rule have been revised to align their values with the CY 2011 MPFS Final Rule policies. These changes are discussed in the CY 2011 MPFS Final Rule Correction Notice and revised RVU values will be found in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. In addition to RVU revisions, changes have been made to some HCPCS code payment indicators in order to reflect the appropriate payment policy. Procedure status indicator changes will also be reflected in Addendum B and Addendum C of the CY 2011 MPFS Final Rule Correction Notice. Other payment indicator changes will be included, along with the RVU and procedure status indicator changes, in the CY 2011 MPFS Final Rule Correction Notice public use data files located at **http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp** on the Centers for Medicare & Medicaid Services (CMS) website. Changes to the physician work RVUs and payment indicators can be found in the Attachment to CR 7300, which is available at **http://www.cms.gov/Transmittals/downloads/R833OTN.pdf** on the CMS website.

Due to these revisions, the conversion factor (CF) associated with the CY 2011 MPFS Final Rule has been revised. This CF will be published in the CY 2011 MPFS Final Rule Correction Notice. Legislative changes subsequent to issuance of the CY 2011 MPFS Final Rule have led to the further revision of the values published in the CY 2011 MPFS Final Rule Correction Notice, including a change to the conversion factor. As such, the MPFS database (MPFSDB) has been revised to include MPFS policy and payment indicator revisions described above, as well as relevant statutory changes applicable January 1, 2011. A new MPFSDB reflecting payment policy as of January 1, 2011, has been created and made available.

A summary of the recent statutory provisions included in the revised MPFS payment files is as follows.

1. Physician Payment and Therapy Relief Act of 2010

On November 30, 2010, President Obama signed into law the *Physician Payment and Therapy Relief Act of 2010*. As a result of the *Physician Payment and Therapy Relief Act of 2010* a new reduced therapy fee schedule amount (20 percent reduction on the PE component of payment) will be added to the MPFS payment file. Per this Act, CMS will apply the CY 2011 MPFS Final Rule policy of a 25 percent Multiple Procedure Payment Reduction (MPPR) on the PE component of payment for therapy services furnished in the hospital outpatient department and other facility settings that are paid under Section 1834(k) of the Social Security Act, and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 of the Social Security Act. This change is detailed in recently released CR7050. CMS published MLN Matters® article 7050, related to CR 7050, which may be reviewed at **http://www.cms.gov/MLNMattersArticles/downloads/MM7050.pdf** on the CMS website. This Act also made the therapy MPPR not budget neutral under the Physician Fee Schedule (PFS) and, therefore, the redistribution to the PE RVUs for other services that would otherwise have occurred will not take place. The revised RVUs, in accordance with this new statutory requirement, are included in the revised CY 2011 MPFS payment files.

2. Medicare and Medicaid Extenders Act (MMEA) of 2010

On December 15, 2010, President Obama signed into law the *Medicare and Medicaid Extenders Act (MMEA) of 2010*. This new legislation contains a number of Medicare provisions which change or extend current Medicare Fee-For-Service program policies. A summary of MPFS-related provisions follows.

- **Physician Payment Update**

  Section 101 of the MMEA averts the negative update that would otherwise have taken effect on January 1, 2011, in accordance with the CY 2011 MPFS Final Rule. The MMEA provides for a zero percent update to the MPFS for claims with dates of service January 1, 2011, through December 31, 2011. While the MPFS update will be zero percent, other changes to the RVUs (e.g., miss valued code initiative and rescaling of the RVUs to match the revised Medicare Economic Index weights) are budget neutral. To make those changes budget neutral, CMS must make an adjustment to the conversion factor so the conversion factor will not be unchanged in CY 2011 from CY 2010. The revised conversion factor to be used for physician payment as of January 1, 2011, is $33.9764.

  The calculation of the CY 2011 conversion factor is illustrated in the following table.

December 2010 Conversion Factor		**$36.8729**
MMEA "Zero Percent Update"	0.0 percent (1.000)	
CY 2011 RVU Budget Neutrality Adjustment	0.4 percent (1.0043)	
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.3 percent (0.9175)	
CY 2011 Conversion Factor		$33.9764

  The revised CY 2011 MPFS payment files will reflect this conversion factor.

- **Extension of Medicare Physician Work Geographic Adjustment Floor**

  Current law requires the payment rates under the MPFS to be adjusted geographically for three factors to reflect differences in the cost of provider resources needed to furnish MPFS services: physician work, practice expense, and malpractice expense. Section 3102 of the *Affordable Care Act* extended the 1.0 floor on the physician work Geographic Practice Cost Index (GPCI) for services furnished though December 31, 2010. Section 103 of the MMEA extends the existing 1.0 floor on the physician work GPCI for services furnished through December 31, 2011. Updated CY 2011 GPCIs can also be found in the attachment to CR 7300 as noted previously.

- **Extension of MPFS Mental Health Add-On**

  Section 138 of the *Medicare Improvements for Patients and Providers Act (MIPPA) of 2008* increased the Medicare payment amount for specific "Psychiatry" services by 5 percent, effective for dates of service July 1, 2008, through December 31, 2009. Section 3107 of the *Affordable Care Act* extended this provision retroactive to January 1, 2010, through December 31, 2010. Section 107 of the *Medicare & Medicaid Extenders Act* (MMEA) extends the five percent increase in payments for these mental health services, through December 31, 2011. This five percent increase will be reflected in the revised CY 2011 MPFS payment files. A list of Psychiatry HCPCS codes that represent the specified services subject to this payment policy can also be found in the attachment to CR 7300.

- **Extension of Exceptions Process for Medicare Therapy Caps**

  Under the *Temporary Extension Act of 2010*, the outpatient therapy caps exception process expired for therapy services on April 1, 2010. Section 3103 of the *Affordable Care Act* continued the exceptions process through December 31, 2010.

Section 104 of the MMEA extends the exceptions process for outpatient therapy caps through December 31, 2011. **Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate**, for services furnished on or after January 1, 2011, through December 31, 2011.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year on January 1, 2011. For physical therapy and speech language pathology services combined, the limit on incurred expenses is $1,870. For occupational therapy services, the limit is $1,870. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached.

- **Extension of Moratorium That Allowed Independent Laboratories to Bill for the Technical Component (TC) of Physician Pathology Services Furnished to Hospital Patients**
  Under previous law, a statutory moratorium allowed independent laboratories to bill a carrier or a MAC for the TC of physician pathology services furnished to hospital patients. This moratorium expired on December 31, 2009. Section 3104 of the *Affordable Care Act* extended the payment to independent laboratories for the TC of certain physician pathology services furnished to hospital patients retroactive to January 1, 2010, through December 31, 2010. The MMEA restores the moratorium through CY 2011. Therefore, independent laboratories may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed. This policy is effective for claims with dates of service on or after January 1, 2011, through December 31, 2011.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DEMPOS) Updates

The following HCPCS codes will not be discontinued as of December 31, 2010:

- L3660 SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Abduct restrainer canvas &web);

- L3670 SHOULDER ORTHOSIS, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (SD: Acromio/clavicular canvas & web); and

- L3675 SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, and PREFABRICATED INCLUDES FITTING AND ADJUSTMENT (SD: Canvas vest SO).

These three "L" codes will continue to stay active codes for January 1, 2011. Instruction for billing and payment will remain the same for these three "L" codes. Medicare contractors will pay for codes L3660, L3670, and L3675 with dates of service on or after January 1, 2011, using the following 2011 DMEPOS fee schedule amounts:

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.

	JURIS	CATG	L3660	L3670	L3675
AL	D	PO	$85.06	$118.57	$145.25
AR	D	PO	$85.06	$97.17	$145.24
AZ	D	PO	$100.69	$124.79	$141.00
CA	D	PO	$100.69	$124.79	$141.00
CO	D	PO	$111.02	$93.60	$146.04
CT	D	PO	$113.42	$93.60	$141.00
DC	D	PO	$85.06	$112.42	$141.00
DE	D	PO	$85.06	$112.42	$141.00
FL	D	PO	$85.06	$118.57	$145.25
GA	D	PO	$85.06	$118.57	$145.25
IA	D	PO	$106.53	$124.79	$143.74
ID	D	PO	$85.06	$97.28	$141.00
IL	D	PO	$85.06	$93.60	$144.48
IN	D	PO	$85.06	$93.60	$144.48
KS	D	PO	$106.53	$124.79	$143.74
KY	D	PO	$85.06	$118.57	$145.25
LA	D	PO	$85.06	$97.17	$145.24
MA	D	PO	$113.42	$93.60	$141.00
MD	D	PO	$85.06	$112.42	$141.00
ME	D	PO	$113.42	$93.60	$141.00
MI	D	PO	$85.06	$93.60	$144.48
MN	D	PO	$85.06	$93.60	$144.48
MO	D	PO	$106.53	$124.79	$143.74
MS	D	PO	$85.06	$118.57	$145.25
MT	D	PO	$111.02	$93.60	$146.04
NC	D	PO	$85.06	$118.57	$145.25
ND	D	PO	$111.02	$93.60	$146.04

	JURIS	CATG	L3660	L3670	L3675
NE	D	PO	$106.53	$124.79	$143.74
NH	D	PO	$113.42	$93.60	$141.00
NJ	D	PO	$87.06	$110.96	$141.00
NM	D	PO	$85.06	$97.17	$145.24
NV	D	PO	$100.69	$124.79	$141.00
NY	D	PO	$87.06	$110.96	$141.00
OH	D	PO	$85.06	$93.60	$144.48
OK	D	PO	$85.06	$97.17	$145.24
OR	D	PO	$85.06	$97.28	$141.00
PA	D	PO	$85.06	$112.42	$141.00
RI	D	PO	$113.42	$93.60	$141.00
SC	D	PO	$85.06	$118.57	$145.25
SD	D	PO	$111.02	$93.60	$146.04
TN	D	PO	$85.06	$118.57	$145.25
TX	D	PO	$85.06	$97.17	$145.24
UT	D	PO	$111.02	$93.60	$146.04
VA	D	PO	$85.06	$112.42	$141.00
VT	D	PO	$113.42	$93.60	$141.00
WA	D	PO	$85.06	$97.28	$141.00
WI	D	PO	$85.06	$93.60	$144.48
WV	D	PO	$85.06	$112.42	$141.00
WY	D	PO	$111.02	$93.60	$146.04
AK	D	PO	$100.22	$148.35	$141.00
HI	D	PO	$107.12	$158.62	$141.00
PR	D	PO	$82.83	$105.08	$169.21
VI	D	PO	$87.06	$110.96	$169.21

In accordance with the statutory Section 1834(a)(14) of the Social Security Act, the above fee schedule amounts were updated for CY 2011 by applying the CY 2011 -0.1 percent update factor to the CY 2010 fee schedule amounts. The CY 2011 payment amounts for codes L3660, L3670, and L3675 will be posted as a public use file at:
http://www.cms.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp on the CMS website.

Additional Information
The official instruction, CR7300, issued to your carrier, FI, RHHI, DME MAC, and A/B MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R833OTN.pdf** on the CMS website. If you have any questions, please contact your carrier, RHHI, FI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Implementation of New Reasonable Useful Lifetime (RUL) Policy for Stationary and Portable Oxygen Equipment (MM7213) (OXY)

MLN Matters® Number: MM7213
Related CR Release Date: April 8, 2011
Related CR Transmittal #: R871OTN

Related Change Request (CR): 7213
Effective Date: May 8, 2011
Implementation Date: May 8, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs) for portable and stationary oxygen equipment for Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 7213 implements changes to address situations in which a beneficiary has both portable and stationary oxygen equipment and the RUL for one piece of equipment expires before the RUL for the other piece of equipment has been reached.

Background
CR 7213 results in systems changes to establish new RUL policies for instances where the beneficiary has both portable and stationary oxygen equipment and the RUL for one piece of equipment expires before the RUL for the other piece of equipment has been reached. In most cases, a beneficiary who requires both stationary and portable oxygen will have developed the need for both stationary and portable oxygen at the same time, will have received their stationary and portable oxygen equipment at the same time, and will be in a situation where the RUL for the stationary oxygen equipment ends at the same time that the RUL for the portable oxygen equipment ends. At the end of the RUL, the beneficiary can elect to obtain new oxygen equipment.

Payment for portable oxygen equipment under Medicare is made as an add-on to the monthly payment amount for oxygen and oxygen equipment, which includes payment for stationary equipment, stationary oxygen contents, and portable oxygen contents. As a general rule, the same supplier that furnishes the stationary oxygen equipment to a beneficiary and receives the monthly payment for oxygen and oxygen equipment should also be furnishing the portable oxygen equipment to that beneficiary since a component of the payment for portable oxygen (portable oxygen contents) is included in the monthly payment amount for oxygen and oxygen equipment. A supplier of either stationary oxygen equipment or portable oxygen equipment that has furnished the equipment for 36 months of continuous use must continue to furnish the oxygen equipment to the beneficiary for the remainder of the RUL. Under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program, this responsibility does not transfer to a contract supplier if the supplier is not awarded a contract. When the RUL for oxygen equipment ends and the beneficiary elects to obtain replacement oxygen equipment, the replacement equipment must be furnished by a contract supplier and cannot be furnished by a non-contract supplier.

At the start of a competitive bidding program, a supplier that is not awarded a contract for furnishing oxygen and oxygen equipment under the program may elect to continue or may be required to continue furnishing oxygen and oxygen equipment to beneficiaries they are currently serving:

1. They may elect to be a grandfathered supplier for oxygen and oxygen equipment that has not yet reached the 36-month rental cap for all of their current customers who are Medicare beneficiaries residing in a DMEPOS Competitive Bidding Area (CBA); or

2. They are required to continue furnishing oxygen and oxygen equipment for which they received the 36th rental payment prior to the start of the program for the remainder of the RUL established for the equipment.

Note: These new RUL policies outlined below apply to oxygen and oxygen equipment furnished to Medicare beneficiaries in general and are not restricted to oxygen and oxygen equipment furnished to beneficiaries residing in CBAs.

Key Points of CR7213
The following rules apply in situations where the beneficiary is using both stationary and portable oxygen equipment with different RUL end dates.

- When the RUL of a beneficiary's portable oxygen equipment differs from the RUL of the beneficiary's stationary oxygen equipment, the RUL of the stationary oxygen equipment shall govern the application of RUL-based rules and processes for both types, stationary and portable, of oxygen equipment.

- Until such time, as the end date of the RUL of the stationary oxygen equipment is reached, the supplier must continue to furnish both the portable and stationary oxygen equipment.
    - If the end date of the RUL of the portable oxygen equipment **precedes** the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen equipment is adjusted (**extended**) to coincide with the end date of the RUL of the stationary oxygen equipment.

- If the end date of the RUL of the portable oxygen equipment **follows** the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen equipment is adjusted (**shortened**) to coincide with the end date of the RUL of the stationary oxygen equipment.

- When the end date of the RUL of the stationary oxygen equipment occurs, the beneficiary may elect to obtain replacement of both the stationary and the portable oxygen equipment.

- If the beneficiary elects to obtain replacement of the stationary and the portable oxygen equipment, both types of oxygen equipment must be replaced at the same time.

- When the stationary and the portable oxygen equipment are replaced, a new 36-month rental period and new RUL is started for both the replacement stationary oxygen equipment and the replacement portable oxygen equipment.

- Beginning January 1, 2011, a beneficiary who resides in a DMEPOS CBA may obtain replacement of both the stationary and portable oxygen systems only from a contract supplier having a competitive bidding contract for the CBA in which the beneficiary permanently resides.

- A grandfathered supplier for oxygen and other grandfathered equipment as of January 1, 2011, who has continued to furnish such equipment that has not yet reached the 36-month rental cap, does not qualify to furnish replacement equipment once the end date of the RUL of the stationary equipment is reached, if the beneficiary resides in the CBA when the end of the RUL has been reached (unless the status of the grandfathered supplier has changed to a contract supplier for the current round of the DMEPOS competitive bidding program).

Additional Information
If you have questions, please contact your Medicare DME MAC or RHHI at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the Centers for Medicare & Medicaid Services (CMS) website. For complete details regarding this CR please see the official instruction (CR 7213) issued to your Medicare RHHI or DME MAC. That instruction may be viewed by going to **http://www.cms.gov/Transmittals/downloads/R871OTN.pdf** on the CMS website.

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

MLN Matters® Number: MM7041 Revised
Related CR Release Date: April 20, 2011
Related CR Transmittal #: R874OTN
Related Change Request (CR) #: 7041
Effective Date for Providers: July 1, 2011
Implementation Date: July 5, 2011

Note: *This article was revised on April 21, 2011, to reflect a revised CR7041 issued on April 20, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing CR7041 have been revised. Also, a reference to MLN Matters® article SE1106 was added in the Additional Information section to give important reminders about the implementation of HIPAA 5010 and D.O., including Fee For Service implementation schedule and readiness assessments.*

Provider Types Affected
This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment (DME) MACs, and fiscal intermediaries (FIs) including regional home health intermediaries(RHHIs)).

Provider Action Needed
This article is based on Change Request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N Version 5010. Be sure your billing staff is aware of these changes.

Background

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

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

Key Points for Medicare Billers:

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at **http://www.cms.gov/Transmittals/downloads/R874OTN.pdf** on the CMS website.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional Information

If you have questions, please contact your MAC and/or FI/carrier at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction (CR 7041) issued to your MAC and/or FI/carrier is available at **http://www.cms.gov/Transmittals/downloads/R874OTN.pdf** on the CMS website. You may also want to review MLN Matters® article MM7306 at **http://www.cms.gov/MLNMattersArticles/downloads/MM7306.pdf** on the CMS website. You may also want to review MLN Matters® article SE1106 available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1106.pdf** for important reminders about the implementation of HIPAA 5010 and D.O., including Fee For Service implementation schedule and readiness assessments.

July 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7357) (DRU)

MLN Matters® Number: MM7357
Related CR Release Date: March 25, 2011
Related CR Transmittal #: R2182CP

Related Change Request (CR) #: 7357
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected

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

Provider Action Needed
This article is based on Change Request (CR) 7357, which instructs Medicare contractors to download and implement the July 2011 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2011, January 2011, October 2010, and July 2010 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 1, 2011, with dates of service July 1, 2011, through September 30, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare 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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

Files	Effective for Dates of Service
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
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010

Additional Information
If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction (CR 7357) issued to your Medicare MAC, carrier, and FI may be found at **http://www.cms.gov/transmittals/downloads/R2182CP.pdf** on the CMS website.

New K Codes for Suction Pumps and Wound Dressings (MM7411) (SPE)

MLN Matters® Number: MM7411
Related CR Release Date: April 29, 2011
Related CR Transmittal #: R2206CP

Related Change Request (CR) #: CR 7411
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
Providers and suppliers who bill Medicare Administrative Contractors (A/B MACs) or Durable Medical Equipment contractors (DME MACs) for providing suction pumps and accompanying surgical dressings to Medicare beneficiaries.

Provider Action Needed
Effective July 1, 2011, Medicare will allow four new K codes for billing suction pumps and accompanying surgical dressings. Ensure that your billing staffs are aware of these new K codes, which are effective for dates of service on or after July 1, 2011. The codes and their descriptors are as follows:

- K0743 - SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS;
- K0744 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS;
- K0745 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL; PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES; and

- K0746 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES.

Note: *The coverage type for these codes is "C," and their coverage is subject to your contractor's discretion. Further, the addition of these codes does not imply their coverage by Medicare.*

Additional Information
You can find the official instruction, CR7411, issued to your A/B MAC or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R2206CP.pdf** on the Centers for Medicare & Medicaid (CMS) website. If you have any questions, please contact you're 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.

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

MLN Matters® Number: MM7397
Related CR Release Date: May 13, 2011
Related CR Transmittal #: R2214CP
Related Change Request (CR) #: 7397
Effective Date: June 29, 2011
Implementation Date: June 29, 2011

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/R2214CP.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.

Power Mobility Device Face-to-Face Examination Checklist (SE1112) (MOB)

MLN Matters® Number: SE1112
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 Special Edition (SE) MLN Matters® article is intended for physicians or treating practitioners who prescribe a Power Mobility Device (PMD) for Medicare beneficiaries. (In addition to a physician; a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD.) The article should also be of interest to Durable Medical Equipment (DME) suppliers who submit claims to DME Medicare Administrative Contractors (DME MACs) for such equipment.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) is issuing this article as solely an educational guide to improve compliance with documentation requirements for the face-to-face examination that occurs prior to the physician or treating practitioner ordering a PMD for their Medicare patients. The article presents a checklist, which is a tool that providers may wish to use for this examination, in addition to some helpful tips to help providers and suppliers avoid denial of their PMD claims. **The use of this guide is not mandatory and does not ensure Medicare payment for a PMD, even if signed and dated.**

Background
Power wheelchairs and power operated vehicles (also known POVs or scooters) are collectively classified as Power Mobility Devices (PMDs) and are covered under the Medicare Part B benefit. CMS defines a PMD as a covered item of DME that includes a power wheelchair or a POV that a beneficiary uses in the home. Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as Mobility Assistive Equipment (MAE), which includes a continuum of technology from canes to power wheelchairs.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of portions of the medical record essential for supporting the medical necessity for the PMD in the beneficiary's home. In order to document the need for a PMD there are a few specific statutory requirements that must be met before the prescription is written:

1. An in-person visit between the ordering physician and the beneficiary must occur. This visit must document the decision to prescribe a PMD.

2. A medical evaluation must be performed by the ordering physician. The evaluation must clearly document the patient's functional status with attention to conditions affecting the beneficiary's mobility and their ability to perform activities of daily living within the home. This may be done all or in part by the ordering physician. If all or some of the medical examination is completed by another medical professional, the ordering physician must sign off on the report and incorporate it into their records.

3. Items 1 and 2 together are referred to as the face-to-face exam. Only after the face-to-face examination is completed may the prescribing physician write the prescription for a PMD. This prescription has seven required elements and is referred to as the seven-element order which must be entered on the prescription only by the physician.

4. The records of the face-to-face examination and the seven-element order must be forwarded to the PMD supplier within 45 days of the completion of the face-to-face examination

5. CMS' National Coverage Determination requires consideration as to what other items of mobility assistive equipment (MAE), e.g., canes, walkers, manual wheelchair, etc., might be used to resolve the beneficiaries mobility deficits. Information addressing MAE alternatives must be included in the face-to-face medical evaluation.

CMS offers a checklist that providers may wish to use in the examination and documentation process and can be found in the 'Attachment' section at the end of this article. The checklist contains the information that is essential for Medicare to determine the medical necessity of the PMD. **Please note, the checklist contained in this article is a guide and does not replace the underlying medical records.** The checklist outlines the information that is essential for Medicare to have in determining whether payment should be made for a PMD. It is provided for educational purposes and serves to help providers understand the types of information which Medicare believes is critical for providers to document the patient's medical need in the home and that the device can be used safely.

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

Tips to Avoid Denial of PMD Claims
Medical records should contain enough information to support the coverage for a PMD. Currently, audits show medical records commonly lack documentation that justifies the need for payment.

The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must be directly related to the patient's use of a PMD. Key items to be addressed are:

- Why does the patient require the use of a PMD **in the home** to safely and effectively accomplish Activities of Daily Living (ADLs)?
  - Examples of ADLs include but are not limited to bathing, grooming, dressing, toileting.
  - What are important medical history factors that demonstrate the patient's mobility limitations?

- Do the physical examination findings support the patient's claimed functional status (mobility level)?
  - **Physical Examination (PE):** The information provided in the PE must support the pertinent history above. The information must not be recorded in vague and subjective terms (e.g. weak, breathless, tired, etc), but instead must provide quantifiable, objective measures or tests of the abnormal characteristic (e.g. range of motion; manual muscle test scores; heart rate/respiratory rate/pulse oximetry). Each medical record is expected to be individualized to the unique characteristics of the patient. **Included in all exams must be a detailed description of the patient's observed ability or inability to transfer and/or walk.** Examples of other patient physical findings that would commonly be relevant to describe medical need for and ability to use a PMD include:
    - Height and weight;
    - Limb abnormalities;
    - Strength, tone, coordination, reflexes, balance;
    - Heart rate, blood pressure, respiratory rate (at rest and with exertion)
    - Joint swelling, range of motion, erythema, subluxation;
    - Description of limb loss; and
    - Cardiopulmonary exam

- If the patient is thought to require a PMD due to respiratory illness or injury:
  - Does the patient use home oxygen? If yes, what is the frequency, duration, delivery system, and flow rate denoted? How far does the patient report that she/he can walk or self-propel a manual wheelchair before becoming short of breath (with best oxygenation provided)? Describe the ADLs that make him/her short of breath in the home (with best oxygenation provided) and the interventions that palliate them. How have these signs/symptoms changed over time?

- If the patient is thought to require a PMD due to cardiovascular illness or injury:
  - Specifically, describe any clinically significant increased heart rate, palpitations, or ischemic pain that occurs or worsens when the patient attempts or performs ADLs within the home (with best oxygenation provided)? What palliates these signs/symptoms? How far does the patient report that she/he can walk or self-propel a manual wheelchair before experiencing these signs/symptoms? How have these signs/symptoms changed over time?

- If the patient is thought to require a PMD due to neuromusculoskeletal illness or injury or malformed body member:
  - Describe the patient's impairments. For example, does the patient exhibit joint/bone signs/symptoms, changes in strength, coordination or tone? How do these signs/symptoms relate to the patient's functional state and the ability to perform ADLs in specific? How far does the patient report that she/he can walk or self-propel a manual wheelchair before these signs/symptoms interrupt that activity? How have these signs/symptoms changed over time?

Illustrative Example of Medical Record Documentation
This entry may result in a claim DENIED:

Mr. Smith is a male, age 72, with Chronic Obstructive Pulmonary Disease (COPD) who over the last few weeks has been having more Shortness of Breath (SOB). He states he is unable to walk for me today because he is too tired. Therefore he needs a PMD.

Instead consider an entry with this level of detail and support:

Mr. Smith is a 72 yo male with COPD, worsening gradually over the past year despite compliant use of XYZ meds, nebulizers and rescue inhalers. PFT's (attached) demonstrate the decline in lung function over the last 12 months. Now with the constant use of 2-3L NC O2 at home for the last month, he still can no longer walk to the bathroom, about 30 feet from his bed without significant SOB and overall discomfort. The kitchen is further from his bed. He says his bed/bath doorways and halls are wide enough for a scooter that will bring him to his toilet, sink and kitchen, all of which are on the same floor.
VS 138/84, Ht rate 88 RR 16 at rest on 3L NC
Vision- sufficient to read newspaper with glasses on
Cognition- OX3. Able to answer my questions without difficulty.
Ht XX Wt YY
Ambulation - Sit to stand was done without difficulty. Patient attempted to ambulate 50' in hallway, but needed to stop and rest 2 x's before he could accomplish. HR at first stop point (about 25') was 115 and RR was 32. Patient became slightly diaphoretic.
Lung exam - Hyperresonant percussion and distant breath sounds throughout. Occ wheezes.
Neuro- Hand grips of normal strength bilat. Patient able to maintain sit balance when laterally poked.
Steps carefully around objects in the room.
Alternative MAE equipment - Pt has attempted to use cane, walker or manual wheelchair unsuccessfully due to extreme fatigue with slight exertion described above.
Assessment - Pt seems good candidate for a scooter to carry him the necessary distances in his home to use toilet/sink and kitchen facilities. Home seems amenable to this device.

Accurate and complete documentation in the physician records regarding the face-to-face examination is extremely important to ensure the patient receives an appropriate PMD.

Additional Information

If you have any questions, please visit the website of your DME MAC or contact them at their toll-free number. Their Web address and toll-free number are available at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

ATTACHMENT - Sample Checklist for the PMD Examination

Please note, this checklist is not mandatory and does not replace the underlying medical records.

The medical record for the patient includes the following history:

_____ Signs/Symptoms that limit ambulation;

_____ Diagnoses that are responsible for these signs/symptoms;

_____ Medications or other treatment for these signs/symptoms;

_____ Progression of ambulation difficulty over time;

_____ Other diagnoses that may relate to ambulatory problems;

_____ How far the patient can ambulate without stopping and with what assistive device, such as a cane or walker;

_____ Pace of ambulation;

_____ History of falls, including frequency, circumstances leading to falls, what ambulatory assistance (cane, walker, wheelchair) is currently used and why it is not sufficient;

_____ What has changed in the patient's condition that now requires the use of a power mobility device;

_____ Reason for inability to use a manual wheelchair; such as assessment of upper body strength;

_____ Why does the patient need a power wheelchair rather than each level of mobility assistive equipment (a cane, walker, optimally configured manual wheelchair, scooter)? What are the reasons that the patient should not or could not use a cane, walker, optimally configured manual wheelchair or power operated vehicle (scooter) in the home to satisfy their needs?; and

_____ Description of the home setting, including the ability to perform activities of daily living in the home, as well as the ability to utilize the PMD in the home.

The physical examination is relevant to the patient's mobility needs and the medical record for the patient contains:

_____ Weight and Height

_____ Musculoskeletal examination

- Arm and leg strength and range of motion;

_____ Neurological examination

- Gait
- Balance and coordination
- If the patient is capable of walking, the report should include a documented observation of ambulation (with use of cane or walker as appropriate)

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

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:

- 2nd Quarter 2011 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2011 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2011 Oral Anticancer Drug Fees

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

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

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

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

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

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

Note: *This article was replaced by article MM7333 on March 15, 2011. The replacement article is available at* ***http://www.cms.gov/MLNMattersArticles/downloads/MM7333.pdf*** *on the Centers for Medicare & Medicaid Services website.*

Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) [This CR Rescinds and Fully Replaces CR7073] (MM7333) (GEN)

MLN Matters® Number: MM7333
Related CR Release Date: March 4, 2011
Related CR Transmittal #: R865OTN

Related Change Request (CR) #:7333
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
This article is for suppliers who submit claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7333. The Centers for Medicare & Medicaid Services (CMS) issued CR7333 to rescind and replace CR7073 dated November 12, 2010. CR7333 provides further guidance to suppliers of DMEPOS, regarding licensing, accreditation, or other mandatory quality requirements that may apply. DMEPOS suppliers should be aware that if they are not identified by the National Supplier Clearing House-Medicare Administrative Contractor (NSC-MAC) as accredited to supply the specific product/service AND they are not exempt from accreditation, their claims will be automatically denied by Medicare. Also be aware that Attachments B and C of CR7333 are updated to include additional Healthcare Common Procedures Coding System (HCPCS) codes. All other information remains the same as that included in CR7073.

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

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

Section 154(b) of the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) added a new subparagraph (F) to Section 1834(a)(20) of the *Social Security Act*. In implementing quality standards under this paragraph the Secretary will require suppliers furnishing items and services directly on or after October 1, 2009, or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible

professionals and other persons (defined below) are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009, accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

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

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

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

Key Points

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

Edits for HCPCS codes in the product categories designated by MIPPA as requiring accreditation will be in effect. This Medicare system edit will auto-deny claims paid for these codes on claims with dates of service on or after July 5, 2011 unless:

1. The DMEPOS supplier has been identified as accredited and verified on their CMS-855S;
2. Or the DMEPOS supplier is currently exempt from meeting the accreditation requirements as listed in Attachment A of this change request; and
3. Medicare system edits will begin this process by phasing in a limited number of product categories and HCPCS codes, as listed in Attachments B and C of this change request. The web address for Attachments B and C is part of the official instruction and may be found in the Additional Information section of this CR7333.

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

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

Note: *Products and services requiring accreditation found on CMS 855S, Section 2D next to the NSC-MAC product codes along with HCPCS codes may be found in Attachment B in CR7333. Their corresponding HCPCS codes may be found in Attachment C. The web address of CR7333 can be found in the Additional Information section of this article.*

Additional Information

The official instruction, CR7333 issued to your DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R865OTN.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.

Capped Rental DME: Enforcement of Payment Requirements for Beneficiary-owned Capped Rental Durable Medical Equipment (DME) (SE1103) (GEN)

MLN Matters® Number: SE1103 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 March 18, 2011, to show that the oxygen equipment requirements were significantly changed on January 1, 2009, as a result of CR6297. Those changes were added to pages 3-5. All other information is the same.*

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

Provider Action Needed
This article is primarily informational and summarizes the findings of the Office of the Inspector General (OIG) report of August of 2010 titled, "A Review of Claims for Capped Rental Durable Medical Equipment." The article contains references to Medicare policy documents that the Center for Medicare & Medicaid Services (CMS) has available to guide suppliers in proper billing of capped rental DME claims, including repairs and maintenance. Suppliers need to be aware of the report findings and proper billing procedures to avoid impact on claims payments. The OIG report provides the details about the findings and it is available at **http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf** on the Internet. In addition to the procedures for proper billing, be sure to follow all proper documentation requirements to assure that the documentation adequately supports your claims for payment.

Background
The DME items covered by Medicare are medical equipment that often requires maintenance and repairs, and Medicare pays DME suppliers for that maintenance and those repairs in certain circumstances. Capped rental DME is a specific category of DME for which Medicare pays a fee schedule amount that is capped after 13 consecutive months of rental to a beneficiary.

Section 5101 of the *Deficit Reduction Act of 2005* (DRA) revised the payment rules for capped rental DME so that ownership of the equipment would transfer to the beneficiaries after 13 continuous months of rental. During the audit conducted by the OIG's office, approximately 500 claims were reviewed and 34 beneficiary interviews were conducted. The finding of the claims reviews and beneficiary interviews was that claims for repairs of beneficiary-owned capped rental DME were improperly paid. Consequently the OIG recommended strategies to reduce improper payments and strengthen program integrity.

Key Points
DME is medical equipment that can withstand repeated use, serves a medical purpose, is not useful in the absence of an illness or injury, and is appropriate for home use. The following are the summarized findings listed in the OIG report:

- **From 2006 to 2008, suppliers erroneously billed Medicare for routine maintenance and servicing of capped rental DME with rental periods after implementation of the DRA.**
- **From 2006 to 2008, suppliers erroneously billed Medicare for repairs for beneficiary-rented capped rental DME.**
- **In 2007, Medicare allowed payment for some repair claims of beneficiary-owned capped rental DME that failed to meet payment requirements.** OIG review of supplier records indicate that 27 percent of allowed repair claims for beneficiary-owned capped rental DME in 2007 lacked medical necessity, service, or delivery documentation, or represented repairs to DME still under manufacturer or supplier warranties.
- **In 2007, Medicare allowed payment for repair claims for capped rental DME that were questionable because of missing information and high dollar allowed amounts for repairs relative to replacement costs.**

- **Supplier practices adversely affected some beneficiaries with high-cost repairs.** Beneficiaries with high-cost allowed repairs reported that some suppliers failed to properly customize Power Mobility Devices (PMD), rendering the PMDs useless to them, and that other suppliers did not offer loaner equipment when repairing PMDs, leaving some beneficiaries immobile. Some beneficiaries reported difficulties in contacting suppliers, and record reviews indicated that suppliers charged some beneficiaries service fees for repairs of capped rental DME. Finally, other beneficiaries reported that suppliers failed to provide instructions about the proper use of their equipment and information about repair charges.

Several payment policy changes have been implemented to improve the accuracy of payment for beneficiary-owned capped rental items.

- **Capped Rental Items** - The DRA required changes to payments for maintenance and servicing of capped rental items so that Medicare payment is no longer made at every 6 months for maintenance and servicing. Instead, once the beneficiary owns the capped rental item, Medicare will cover reasonable and necessary repairs and servicing, provided the repairs are not to items still covered (parts and/or labor) by the manufacturer's warranty. These changes are discussed in Change Request (CR) 5461, issued by CMS on February 2, 2007. That CR is available at **http://www.cms.gov/Transmittals/downloads/R1177CP.pdf** on the CMS website. A companion MLN Matters® article, MM5461 is also available at **http://www.cms.gov/MLNMattersArticles/downloads/MM5461.pdf** on the same site

- **Oxygen and Oxygen Equipment** - The *Medicare Improvements for Patients and Providers Act* (MIPPA) as of January 1, 2009, eliminated the requirement for suppliers to transfer title to oxygen equipment. Instead, the supplier who furnished the stationary and/or portable oxygen equipment during the 36-month rental period is required to continue furnishing the stationary and/or portable equipment following the 36-month rental period for any period of medical need for the remainder of the equipment's reasonable useful lifetime (5 years). This requirement includes situations where there is a temporary break in need or break in use of the equipment of any duration after the 36-month rental cap. In such situations, the supplier remains responsible for furnishing the oxygen equipment after the break in need for the remainder of the reasonable useful lifetime during which the medical need for oxygen and oxygen equipment continues. A new rental period can begin if the equipment is replaced because it is lost, stolen, irreparably damaged, or is replaced after the reasonable useful lifetime expires.

- Effective for certain oxygen equipment (i.e., oxygen concentrators and oxygen transfilling equipment) but not for other gaseous or liquid oxygen equipment (stationary or portable), a maintenance and servicing fee can be billed with the "MS" modifier and is paid every 6 months, beginning 6 months after the 36th paid rental month or end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. The maintenance and servicing fee will be updated on an annual basis through program instructions based on the covered item update for DME. The payment covers all maintenance and servicing through the following 6 months that is needed in order to keep the oxygen equipment in good working order. A single payment ($65.93 for dates of service January 1, 2011, through December 31, 2011), is made per beneficiary regardless of the number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment), regardless of when the maintenance and servicing is performed during each 6-month period, and regardless of how often the equipment must be maintained and serviced. The supplier is required to make at least one maintenance and 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. These changes are discussed in Change Request (CR) 7248, issued by CMS on January 24, 2011.

- As discussed in CR6297, excerpted from MLN Matters® article MM6297): the monthly payment amount for oxygen and oxygen equipment covers equipment, contents, supplies and accessories. The supplier who received payment for furnishing the oxygen and oxygen equipment during the 36-month rental period is responsible for continuing to furnish any accessories and supplies necessary for the effective use of the equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable useful lifetime of the equipment. Therefore, separate payment shall not be made for replacement of supplies and accessories for use with oxygen equipment that are furnished on or after January 1, 2009. This applies to any supply or accessory billed under a miscellaneous HCPCS code, any codes added to the HCPCS in the future, or under the following current HCPCS codes:

HCPCS Code	Descriptor
A4608	Transtracheal oxygen catheter, each
A4615	Cannula, nasal
A4616	Tubing (oxygen), per foot
A4617	Mouth piece
A4619	Face tent
A4620	Variable concentration mask
A7525	Tracheostomy mask, each
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0560	Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353	Regulator
E1354	Wheeled cart for portable cylinder or concentrator (Added to HCPCS effective January 1, 2009)
E1355	Stand/Rack
E1356	Battery pack/cartridge for portable concentrator (Added to HCPCS effective January 1, 2009)
E1357	Battery charger for portable concentrator (Added to HCPCS effective January 1, 2009)
E1358	DC Power adapter for portable concentrator (Added to HCPCS effective January 1, 2009)

CMS will continue to improve its claims processing edits to improve the accuracy of payments for capped rental DME.

Additional Information
The entire OIG report, "A Review of Claims for Capped Rental Durable Medical Equipment," referenced in this SE1103 is available at **http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf** on the Internet. CR6297 is available at http://www.cms.gov/Transmittals/downloads/R421OTN.pdf and the related article, MM6297 is at **http://www.cms.gov/MLNMattersArticles/downloads/MM6297.pdf** on the CMS website. If you have any questions, please contact your Medicare DME MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Durable Medical Equipment National Competitive Bidding: Correction to Permit Payment for Certain Grandfathered Accessories and Supplies (MM7389) (GEN)

MLN Matters® Number: MM7389
Related CR Release Date: May 6, 2011
Related CR Transmittal #: R896OTN

Related Change Request (CR) #: 7389
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for certain grandfathered accessories and supplies furnished to Medicare beneficiaries after the start of a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP).

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 7389 which informs Medicare suppliers and DME MACs that Medicare payment is permissible to a non-contract, grandfathered supplier for furnishing certain purchased, covered accessories or supplies furnished for use with capped rental equipment.

What You Need to Know
There are limitations on the duration of this permission as well as constraints on the applicable Healthcare Common Procedure Coding System (HCPCS) codes. The KY modifier should not be annotated on claims for these HCPCS codes after September 31, 2011.

What You Need to Do
See the Background and Key Points Sections of this article for clarification and details regarding these changes.

Background
Under the Medicare DMEPOS CBP a beneficiary who obtains competitive bidding items in a designated Competitive Bidding Area (CBA) must obtain these items from a contract supplier, unless an exception applies such as the ones presented below exist.

Exception 1:
A beneficiary may continue to obtain a capped rental item from a non-contract supplier if the beneficiary was receiving such rented item from the non-contract supplier when the CBP took effect in the CBA. Such a non-contract supplier would be considered a "grandfathered supplier" with respect to such rented item and such beneficiary for the remainder of the particular item's capped rental period.

Exception 2: (related to exception above)
A beneficiary, who continues to obtain a capped rental competitive bidding item from a non-contract grandfathered supplier, may also obtain certain purchased, covered accessories or supplies furnished for use with such rented "grandfathered" capped rental equipment from the same non-contract grandfathered supplier. The purchased, covered accessories or supplies that are subject to this exception, identified by applicable HCPCS codes, are as follows:

- Continuous Positive Airway Pressure Devices, Respiratory Assistive Devices, and Related Supplies and Accessories - A4604, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, and E0562;
- Hospital Beds and Related Accessories - E0271, E0272, E0280, and E0310; and
- Walkers and Related Accessories - E0154, E0156, E0157 and E0158

Previously, non-contract grandfathered suppliers submitting claims for purchased, covered accessories or supplies under this exception were told to use the KY modifier on claims for such items with dates of service on or after January 1, 2011.

Key Points in CR7389
Effective October 1, 2011, the KY modifier is not required on these claims. Any claims submitted after September 30, 2011 with the KY modifier will be denied.

Medicare payment may be made to a non-contract, grandfathered supplier for furnishing certain purchased, covered accessories or supplies furnished for use with capped rental equipment, provided the non-contract supplier is also furnishing the capped rental equipment on a grandfathered basis. The purchased, covered accessories or supplies that are subject to this policy, identified by applicable HCPCS codes, are previously listed.

After the rental payment cap for the grandfathered equipment is reached:

- The beneficiary should obtain covered accessories and supplies only from a contract supplier;
- The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies;
- Medicare payment will no longer be made to a non-contract, grandfathered supplier for furnishing such purchased accessories or supplies and
- These claims will be denied, using the following messages:
  - B20 - Procedure /service was partially or fully furnished by another provider;
  - N211 - You may not appeal this decision;
  - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier; and
  - MSN 8.72: This item must be provided by a contract supplier under the DMEPOS competitive bidding program. You should not be billed for this item or service. You do not have to pay this amount. There are no Medicare appeal rights related to this item.

Medicare contractors will also assign group code CO (Contractual Obligation).

Additional Information
If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction associated with this CR7389, issued to your Medicare MAC regarding this change may be viewed at

http://www.cms.gov/Transmittals/downloads/R896OTN.pdf on the CMS website. To review a complete listing of links to DME related information you may go to **https://www.cms.gov/center/dme.asp** on the CMS website.

Healthcare Provider Taxonomy Codes April 2011 Update (CEDI Message) (GEN)

Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The X12 837 Professional Implementation Guide used for durable medical equipment (DME) claims requires the use of valid codes contained in the Healthcare Provider Taxonomy Codes (HPTC) set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

The taxonomy code is not required for processing Medicare claims. However, if a taxonomy code is submitted, it must be valid according to the HPTC code set. The HPTC code set is named in the 837 professional implementation guide, thus CEDI must validate the inbound taxonomy codes against this HPTC maintained code source.

The HPTC list is available from the Washington Publishing Company (WPC). To view the April 2011 changes, visit the WPC Web site at: **http://www.wpc-edi.com/codes/taxonomy**, then select "New Codes" for a listing of new HPTCs or "Modifications" for a listing of modified HPTCs.

Please contact the CEDI Help Desk at 866-311-9184 or by e-mail at **ngs.cedihelpdesk@wellpoint.com** if you have questions.

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

MLN Matters® Number: MM7350
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

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 through **Pay.gov**, either via credit card, debit card, or check. CMS will send to the contractor on a regular basis a listing of providers and suppliers (the "Fee Submitter List") that have paid an application fee via **Pay.gov**. However, providers and suppliers are strongly encouraged to submit with their application a copy of their **Pay.gov** 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 Presidentially-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. Attached to CR7350, you will find the complete details, regarding this issue as defined in the PIM revisions. 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 Reminders about HIPAA 5010 & D.0 Implementation (SE1106) (GEN)

MLN Matters® Number: SE1106
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 Special Edition MLN Matters® Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
The implementation of HIPAA 5010 and 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. It is important for new providers enrolling in Medicare to know that Electronic Data Interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

What You Need to Know
Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This Special Edition MLN Matters® Article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 Version 5010 and NCPDP Version D.0 standards. Remember that the 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 Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the

new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.

What You Need to Do

In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

The *Health Insurance Portability and Accountability Act* (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.

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice. More information about Medicare's EDI requirements can be found in the "Medicare Claims Processing Manual," Chapter 24 - "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at **http://www.cms.gov/manuals/downloads/clm104c24.pdf** on the CMS website. Electronic billing and EDI transaction information can be found at **http://www.cms.gov/ElectronicBillingEDITrans/** on the CMS website. This section contains information on:

- EDI transaction and corresponding paper claims requirements;
- Links to those chapters of the "Medicare Claims Processing Manual" that contain further information on these types of transactions;
- The *Administrative Simplification Compliance Act* (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment;
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically; and
- EDI support furnished by Medicare contractors.

Current versions of the transaction standards (ASC X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. Therefore, on January 16, 2009, HHS announced a final rule that replaced the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively. The final rule (CMS-0009-F) titled, "Health Insurance Reform; Modifications to the *Health Insurance Portability and Accountability Act* (HIPAA) Electronic Transaction Standards," can be found at **http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf** on the US Government Printing Office (GSP) website.

Subsequently, CMS is performing activities to convert from processing the ASC X12 Version 4010A1 to HIPAA ASC X12 Version 5010, and the NCPDP Version 5.1 to NCPDP Version D.0.

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date of the regulation until January 1, 2012, the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- **Level I compliance** means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."
- **Level II compliance** means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

The CMS Medicare Fee-for-Service implementation schedule is:

- **Level I** April 1, 2010, through December 31, 2010;
- **Level II** January 1, 2011, through December 31, 2011; and
- **Fully compliant** on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010, and NCPDP EDI standards Version 5.1 with Version D.0. For more information see **http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp** on the CMS website.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare Fee-for-Service. Maintenance will be performed without notification, as needed to support Medicare Fee-for-Service.

Readiness Assessment 1- Have you done the following to be ready for 5010/D.0?
Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 Errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit **http://www.cms.gov/Versions5010andD0/downloads/readiness_1.pdf** to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once. Be sure to start testing Version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful web links go to **http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp** on the CMS website.

Readiness Assessment 2 - What do you need to have in place to test with your MAC?
Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of Versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.

- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:

- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted); and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 National Call presentation on Provider Outreach and Education - Transition Year Activities can be found at **http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf** on the CMS website.

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources can be found at **http://www.cms.gov/Versions5010andD0/** on the CMS website;
- Educational Resources (i.e., Medicare Learning Network® (MLN) articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at **http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp** on the CMS website; and
- The dedicated HIPAA 5010/D.0 Project web page, which includes technical documents and communications at national conferences, can be found at **http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp** on the CMS website.

Errata Requirements and Testing Schedule
HIPAA Version 5010 has new Errata, which can be found at **http://www.cms.gov/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf** on the CMS website. According to the published regulation (Federal Register, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. **Compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.**

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 Errata versions in April 2011.

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading Partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the "Downloads" section at **http://www.cms.gov/ElectronicBillingEDITrans/** on the CMS website.

CMS 5010 Provider Outreach and Education Materials

CMS has developed extensive information and educational resources pertaining to the topics listed below. This information is available on the CMS website:

- Version 5010- the new version of the X12 standards for HIPAA transactions;
- Version D.0 - the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;
- Version 3.0 - a new NCPDP standard for Medicaid pharmacy subrogation.

The information posted at **http://www.cms.gov/Versions5010andD0/01_overview.asp** on the CMS website may be applicable to the healthcare industry at large, or may be specifically Medicare-related information. The "Overview" web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-related standards. The highlights and overview of these pages are as follows:

- **Federal Regulation & Notices** (**http://www.cms.gov/Versions5010andD0/20_Federal_Regulation_and_Notices.asp**)
  This web page contains general information related to federal regulations and notices and contains the following link to the Final Rule for X12 5010, D.0 and 3.0 document. See http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the GPO website.

- **CMS Communications** (**http://www.cms.gov/Versions5010andD0/30_CMS_Communications.asp**)
  This CMS Communications web page includes Versions 5010 & D.0 implementation information and the following downloads:
  - 5010 Implementation Calendar [PDF, 325KB]; see **http://www.cms.gov/Versions5010andD0/Downloads/5010ImplementationCalendar.pdf** on the CMS website.
  - Readiness Assessment - What do you need to have in place to test with your MAC? [PDF, 241KB]; see **http://www.cms.gov/Versions5010andD0/Downloads/Readiness_2.pdf** on the CMS website.

- **Educational Resources** (**http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp**)
  The Educational Resources web page includes information designed to increase national awareness and assist in the implementation of Versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:
  - **Version 5010 Resource Card [PDF, 243KB]** (see **http://www.cms.gov/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf**);
  - **Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0 Fact Sheet [PDF, 1208KB]** (see **http://www.cms.gov/Versions5010andD0/Downloads/w5010TransitionFctSht.pdf**);
  - **Checklist for Level I Testing Activities [PDF, 324 KB]** (see **http://www.cms.gov/Versions5010andD0/Downloads/w5010PrepChklst.pdf**);
  - **Provider Action Checklist for a Smooth Transition [PDF, 333KB]** (see **http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf**); and
  - **Versions 5010 and D.0 MLN Matters® Articles [PDF, 31KB]** (see **http://www.cms.gov/Versions5010andD0/Downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf** on the CMS website).

- **5010 National Calls** (**http://www.cms.gov/Versions5010andD0/V50/**)
  Throughout the implementation of Version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional Information

A Special Edition MLN Matters® article on the ICD-10 code set can be found at

http://www.cms.gov/MLNMattersArticles/downloads/SE0832.pdf on the CMS website. CMS is also using the Open Door Forums and listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the Open Door Forums can be found at **http://www.cms.gov/OpenDoorForums/** on the CMS website. Information about listservs (email updates) can be found at **http://www.cms.gov/AboutWebsite/EmailUpdates/** on the CMS website. If you have any questions, please contact your carrier, FI, A/B MAC or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/ElectronicBillingEDITrans/** on the CMS website.

Medicare Electronic Health Record (EHR) Incentive Payment Process (SE1111) (GEN)

MLN Matters® Number: SE1111
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This article is intended for Medicare Eligible Professionals (EPs), eligible hospitals, including Medicare Advantage affiliated hospitals, and Critical Access Hospitals (CAHs) that are meaningful users of certified Electronic Health Record (EHR) technology.

What You Need to Know
This article describes the payment process for the **Medicare** EHR Incentive Program.

Background
The *American Recovery and Reinvestment Act (Recovery Act) of 2009* provides for incentive payments beginning in 2011 for Medicare EPs, eligible hospitals, including Medicare Advantage affiliated hospitals, and CAHs that are meaningful users of certified EHR technology.

NOTE: For information about the Medicaid EHR Incentive Program, please see **http://www.cms.gov/EhrIncentivePrograms** on the Centers for Medicare & Medicaid Services (CMS) website. For questions about how Medicaid incentive payments will be made, contact your State Agency. Contact information may be found at **http://www.cms.gov/apps/files/statecontacts.pdf** on the CMS website.

Key Points
Who is eligible for the Medicare EHR Incentive Program and how will payments be calculated?
Refer to the following products to determine which providers are eligible and how incentive payments are calculated. Sample payment calculations are provided.

- The "Medicare Electronic Health Record Incentive Program for Eligible Professionals" fact sheet is available at **http://www.cms.gov/MLNProducts/downloads/CMS_eHR_Tip_Sheet.pdf** on the CMS website.
- The "EHR Incentive Program for Medicare Hospitals" fact sheet is available at **http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_Medicare_Hosp.pdf** on the CMS website.
- The "EHR Incentive Program for Critical Access Hospitals" fact sheet is available at **http://www.cms.gov/MLNProducts/downloads/EHR_TipSheet_CAH.pdf** on the CMS website.

What must I do to get a Medicare EHR incentive payment?

- **Make sure you're eligible for the Medicare EHR Incentive Program.** View eligibility guidelines at **http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp** on the CMS website.
- **Get registered.** Registration is now open. Visit **http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp** for more details.

- **Use certified EHR technology.** To receive incentive payments, make sure the EHR technology you are using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology. Visit the Certified EHR Technology Page at **http://www.cms.gov/EHRIncentivePrograms/25_Certification.asp** for more details.

- **Be a Meaningful User.** You have to successfully demonstrate "meaningful use" for a consecutive 90-day period in your first year of participation (and for a full year in each subsequent year) to receive EHR incentive payments. Visit the Meaningful Use Page at **http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp** to learn about meaningful use objectives and measures.

- **Attest for incentive payments.** To get your EHR incentive payment, you must attest (legally state) through Medicare's secure Web site that you've demonstrated "meaningful use" with certified EHR technology. You can get to the secure attestation website through the new attestation page available at **http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage** on the CMS website. For more information on registration, attestation and meaningful use, go to **http://www.cms.gov/EHRIncentivePrograms** on the CMS website.

When will I receive a payment?

- Payments will be made approximately 4-8 weeks after the provider successfully attests to meaningful use, assuming the provider has met the allowed charges threshold. For more information, read the FAQ on payment at **http://questions.cms.hhs.gov/app/answers/detail/a_id/10160/kw/payment/session/L3NpZC84ZW9CZk9yaw%3D%3D** on the CMS website.

How will I receive the incentive payment?

- If you are eligible for an incentive payment, the payment will be made to the taxpayer identification number you selected during registration. The payment will be deposited in the first bank account on file with CMS and will be noted as "EHR Incentive Payment" by the bank.

- If you receive payments for Medicare services via electronic funds transfer, you will receive your Medicare EHR incentive payment the same way. If you currently receive Medicare payments by paper check, you will also receive your first Medicare EHR incentive payment by paper check.

IMPORTANT NOTE: Medicare Administration Contractors (MACs), carriers, and Fiscal Intermediaries (FIs) will not be making these payments. CMS has contracted with a Payment File Development Contractor to make these payments.

- **DON'T:** Call your MAC/Carrier/FI with questions about your EHR incentive payment.
- **INSTEAD:** Call the EHR Information Center. Contact information and hours of operation are contained in the Additional Information section of this article (see below).

Why is the amount less than I thought?

- The Medicare & Medicaid EHR Incentive Program Registration and Attestation System contains a **Status Tab** at the top which will contain the amount of the incentive payment, the amount of tax or nontax offsets applied, and the adjustment reason code for any reduction. Providers will not receive a remittance advice (835) for this payment; however, an electronic remit (820) will be sent to the bank along with the payment. (See the Additional Information section below for contact information related to the offsets.)

- For those receiving paper checks, there will be a tear off pay stub which identifies offsets made to the incentive payment.

Additional Information

For more information about offsets:

- Call the Internal Revenue Service (IRS) toll-free at 800-829-3903 for tax offsets.
- Call the Department of the Treasury, Financial Management Service (FMS) toll free at 800-304-3107 for nontax offsets.

For other Frequently Asked Questions (FAQs) about the EHR Incentive Program, visit **http://www.cms.gov/EhrIncentivePrograms/** on the CMS website.

The Electronic Health Record (EHR) Information Center is open to assist the EHR provider community with inquiries. **EHR Information Center hours of operation** are 7:30 a.m. - 6:30 p.m. (Central Time) Monday through Friday, except federal holidays. The Center's toll free number is 1-888-734-6433 (primary number) or 888-734-6563 (TTY number).

To submit an inquiry to the EHR Information Center, visit **http://questions.cms.hhs.gov/app/ask/p/21,26,1139** on the CMS website.

October 2011 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (MM7425) (GEN)

MLN Matters® Number: MM7425
Related CR Release Date: May 20, 2011
Related CR Transmittal #: R2225CP

Related Change Request (CR) #: 7425
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected
This article is for providers and suppliers submitting claims to Durable Medical Equipment 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) 7425 which provides the DMEPOS October 2011 quarterly update. This update implements necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, single payment amount and supplier files, effective October 1, 2011. Be sure your billing staffs are aware of these changes.

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

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://page2rss.com/page?url=www.dmecompetitivebid.com/palmetto/CBIC.nsf/DocsCat/Home** on the Internet.

Key Points of CR7425
Competitive Bidding ZIP Codes
For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA number. The competitive bidding CBA numbers and associated names are as follows:

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

- 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order); and
- 40141 - Riverside-San Bernardino-Ontario, CA (mail order only).

Public Use Files
The competitive bidding zip codes and single payment amounts per product category and CBA are 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://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home** or by visiting **http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp** on the Centers for Medicare & Medicaid Services (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
The single payment amount is the Medicare allowed payment amount, instead of the previous fee schedule amount, for competitive bidding items for beneficiaries who reside in CBAs. Medicare will pay contract suppliers 80 percent of the single payment amount for each competitively bid item. The beneficiaries will be responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items.

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

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

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

Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amounts for rented enteral nutrition infusion pumps described by HCPCS codes B9000 and B9002, made in accordance with the "Medicare Claims Processing Manual," Section 40.3, Chapter 20, which is available at **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
If you have any questions, please contact your Medicare DME 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. The official instruction associated with this CR7425 issued to your Medicare DME MAC or RHHI regarding this change may be viewed at **http://www.cms.gov/transmittals/downloads/R2225CP.pdf** on the CMS website. For a more expansive coverage of the January 2011 DMEPOS competitive bidding program and HCPCS codes see MLN Matters® article MM7181 at **http://www.cms.gov/MLNMattersArticles/Downloads/MM7181.pdf** on the CMS website.

CMS News Flash (GEN)

It's Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and continue to protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) recommends that patients, health care workers, and caregivers be vaccinated against the seasonal flu. **Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.**

Get Your Flu Vaccine - Not the Flu. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. The risks for complications, hospitalizations and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Health care workers, who may spread the flu to high risk patients, should get vaccinated too. Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care staff, please visit **http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf** and **http://www.cms.gov/AdultImmunizations** on the CMS website

Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and the National Council for Prescription Drug Program's (NCPDP) version D.0 standards as of January 1, 2012. To facilitate the implementation, Medicare has designated Calendar Year 2011 as the official 5010/D.0 transition year. As such, Medicare Administrative Contractors (MACs) will be testing with their trading partners throughout Calendar Year 2011. Medicare encourages its providers, vendors, clearinghouses, and billing services to schedule testing with their local MAC as soon as possible. Medicare also encourages you to stay current on 5010/D.0 news and helpful tools by visiting **http://www.cms.gov/Versions5010andD0/** on its website. **Test early, Test often!**

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the General Equivalence Mappings (GEMs) at **http://www.cms.gov/ICD10** on the ICD-10 website. See the links on that page for 2011 ICD-10-CM and GEMs, and 2011 ICD-10-PCS and GEMs. In addition, CMS has also posted a document, "ICD-10 GEMs 2011 Version Update, Update Summary." This document describes the number of comments CMS received, the type of changes recommended, the types of changes made based on the comments, the types of comments not accepted, and the reasons why some comments were not accepted.

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

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://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf** on the Centers for Medicare & Medicaid (CMS) website.

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 publication titled "**Evaluation and Management Services Guide**" (revised December 2010), is now available in print format from the Medicare Learning Network®. This guide is designed to provide education on medical record documentation and evaluation and management billing and coding considerations. The "*1995 Documentation Guidelines for Evaluation and Management Services*" and the "*1997 Documentation Guidelines for Evaluation and Management Services*" are included in this publication. To place your order, visit **http://www.cms.gov/MLNGenInfo** on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

The Medicare Learning Network® has released a new CD-ROM titled "**The Interactive Guide to the Medicare Learning Network**." This CD-ROM allows for a two-way flow of information between FFS providers and the MLN. Providers and other healthcare professionals can link directly from the products described on the CD-ROM to the MLN webpages and the MLN Catalog of Products. Once there, users can then confidently download and print copies of the most up-to-date and accurate MLN products. To order the CD-ROM through the MLN Product Ordering System, visit **http://www.CMS.gov/MLNProducts** on the CMS website.

Revised! The publication titled "**The National Provider Identifier (NPI): What You Need to Know**" (revised February 2011), is now available in downloadable format. This booklet was created to help you become more familiar with the NPI (established by final rule on January 23, 2004). Covered entities under HIPAA are required by regulation to use NPIs to identify healthcare providers in HIPAA standard transactions. This publication may be downloaded from **http://www.CMS.gov/MLNProducts/downloads/NPIBooklet.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

A new publication titled "**Signature Requirements**" is now available in downloadable format from the Medicare Learning Network® at **http://www.CMS.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf** on the CMS website. This fact sheet is designed to provide education on Signature Requirements to healthcare providers, and includes information on the documentation needed to support a claim submitted to Medicare for medical services.

The Medicare Learning Network® (MLN) is interested in what you have to say. Regardless of whether you have an MLN account or not, you can evaluate the MLN products, services, and activities that you have participated in, received, or downloaded. This MLN page offers a new anonymous evaluation function that allows you to complete an evaluation without logging in. Visit the MLN Opinion Page found at **http://www.CMS.gov/MLNProducts/85_Opinion.asp** and click on "MLN Opinion Page" in the "Related Links Inside CMS" section at the bottom of the page. Click on the underlined title of the product, service, or activity you want to evaluate and click on the "Take the anonymous evaluation for this product" link that will appear on the right-hand side. A new window will open containing the product evaluation.

On March 31, 2011, The Centers for Medicare & Medicaid Services (CMS) published in the Federal Register **proposed rule CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations that implement the Medicare Shared Savings Program (Shared Savings Program) and establish the requirements for Accountable Care Organizations.** CMS has launched a dedicated web page at **http://www.cms.gov/sharedsavingsprogram** for Medicare Fee-For-Service providers and other providers of services and supplies. You may want to bookmark the web page and check back often, as CMS continues to add information on the program.

The National Government Services, Inc. (NGS) Common Electronic Data Interchange (CEDI) which serves Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claim submissions to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) is currently migrating Trading Partners (TPs) from dial-up access to Network Service Vendors (NSVs). The NSVs are not affiliated with the Centers for Medicare & Medicaid Services (CMS) or the DME MAC nor is any NSV specifically endorsed by CMS or the DME MAC. CMS continues to find ways to reduce security risks. As CMS progresses toward a more secure CMS network, this approach is one way to ensure your Medicare data is protected. If you submit claims directly to CEDI and have not made the switch to an NSV, now is the time to reach out to a NSV to avoid any disruption in sending your claims. If you send your DME claims through a clearinghouse or third party biller, contact them to make sure they have made or will be making the switch. Please contact the National Government Services CEDI Help Desk at **ngs.cedihelpdesk@wellpoint.com** or **866-311-9184** if you have any additional questions regarding this initiative. To stay informed of all CEDI updates, visit the CEDI Web site at **http://www.ngscedi.com** and sign up for the CEDI Listserv by selecting the Listserv Registration Link. Select "Join" and follow the prompts to subscribe to the CEDI Listserv.

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/

Billing for Capecitabine (Xeloda®) 500 mg Dosage Form - European Formulation Blister Pack (DRU)

The manufacturer of capecitabine has notified the Food and Drug Administration (FDA) that there is a national shortage of the 500 mg. dosage form of the drug. To accommodate this temporary shortage, the FDA has approved the sale of the European 500 mg. capecitabine formulation in the United States. Pharmacy access to the European formulation is anticipated shortly.

Currently there is no national drug code (NDC) number assigned to the European formulation of 500 mg. capecitabine. Until an NDC number can be assigned, suppliers are instructed to follow the instructions in the Coding Guidelines Section of the Oral Anticancer Drugs Policy Article and use the miscellaneous code J8999. The new NDC number will be posted on the Pricing, Data Analysis, and Coding Contractor web site when it becomes available. At that time, suppliers may use it for claim submission and discontinue use of J8999.

Refer to the *Oral Anticancer Drug LCD and Policy Article* for additional information.

Billing Reminder for Knee Orthoses Addition Codes (O&P)

Recent reviews performed by the Recovery Audit Contractors (RACs) identified errors in the billing of additions to knee orthoses. NHIC, Jurisdiction A DME MAC, is providing the following information for suppliers to avoid claim denials for inappropriate billing of knee orthoses addition codes.

The *Knee Orthoses Local Coverage Determination* (LCD) indicates which addition codes are separately payable when they are provided with a related base code orthoses.

Suppliers are responsible for ensuring that the base code and addition code are compatible and considered reasonable and necessary according to policy.

Addition codes will be denied as not reasonable and necessary if the base orthosis or the addition is not reasonable and necessary.

Prefabricated Knee Orthoses:
The table below provides a list of knee orthoses base codes and the addition codes that are considered as appropriate for use with a given base orthosis.

Base Code	Addition Codes - Eligible for Separate Payment
L1810	None
L1820	None
L1830	None
L1831	None
L1832	L2397, L2795, L2810

Base Code	Addition Codes - Eligible for Separate Payment
L1836	None
L1843	L2385, L2395, L2397
L1845	L2385, L2395, L2397, L2795
L1847	None
L1850	L2397

The table below lists addition codes that describe components or features that can be physically incorporated in the specified prefabricated base orthosis but are considered not reasonable and necessary. Although the additions may be physically incorporated to the base, if they are billed with the related base code, they will be denied as not reasonable and necessary.

Base Code	Addition Codes - Not Reasonable and Necessary
L1810	L2397
L1820	L2397
L1830	L2397
L1831	L2397, L2795
L1832	L2405, L2415, L2492, L2785
L1836	L2397
L1843	L2405, L2492, L2785
L1845	L2405, L2415, L2492, L2785
L1847	L2397, L2795
L1850	L2275

The following table lists addition codes that describe components or features that can be physically incorporated in the specified prefabricated bases orthosis but are considered included in the allowance for the orthosis. The addition codes will be denied as not separately payable if they are billed with the related base code.

Base Code	Addition Codes - Not Separately Payable
L1834	K0672, L2820, L2830, L4002
L1840	K0672, L2320, L2330, L2750, L2780, L2810, L2820, L2830, L4002
L1844	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1846	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1860	K0672, L2820, L2830, L4002

Custom Fabricated Knee Orthoses:
These same rules apply to custom fabricated knee orthoses. The addition codes will be denied as not reasonable and necessary if the base orthosis or the addition is not reasonable and necessary. The table below identifies the base and addition codes that are eligible for separate payment.

Base Code	Addition Codes - Eligible for Separate Payment
L1834	L2795
L1840	L2385, L2390, L2395, L2397, L2405, L2415, L2425, L2430, L2492, L2785, L2795
L1844	L2385, L2390, L2395, L2397, L2405, L2492, L2785
L1846	L2385, L2390, L2395, L2397, L2405, L2415, L2492, L2785, L2795, L2800
L1860	None

The following table lists addition codes that describe components or features that can be physically incorporated in the specified custom fabricated base orthosis but are considered not reasonable and necessary. These addition codes, if they are billed with the related base code, will be denied as not reasonable and necessary.

Base Code	Addition Codes - Not Reasonable and Necessary
L1834	L2397, L2800
L1840	L2275, L2800
L1844	None
L1846	None

Base Code	Addition Codes - Not Reasonable and Necessary
L1860	L2397

The following table lists addition codes that describe components or features that can be physically incorporated in the specified custom fabricated bases orthosis but that are considered included in the allowance for the orthosis. The addition codes will be denied as not separately payable if they are billed with the related base code.

Base Code	Addition Codes - Not Separately Payable
L1834	K0672, L2820, L2830,L4002
L1840	K0672, L2320, L2330, L2750, L2780, L2810, L2820, L2830,L4002
L1844	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830,L4002
L1846	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830,L4002
L1860	K0672, L2820, L2830,L4002

Addition codes that are not listed as either separately payable or not medically necessary in the LCD describe components or features that either cannot be physically incorporated or whose narrative description is incompatible with the specified base orthosis code (e.g., billing a prefabricated base code with an addition code which specifies that the addition code it is only used with custom fabricated orthoses). These incompatible addition codes will be rejected as incorrect coding. Suppliers may resubmit their claim with the appropriate addition code when applicable. As a reminder, appeal rights are not afforded on claims rejected due to incorrect coding.

For additional information, see the *Knee Orthoses LCD, Policy Article* and the *Supplier Manual*. This information is available through the NHIC DME MAC Jurisdiction A Web site at **http://www.medicarenhic.com/dme**

Correct Coding Instructions: A4358 Urinary Collection Bag (GEN)

A4358 (URINARY DRAINAGE BAG, LEG OR ABDOMEN, VINYL, WITH OR WITHOUT TUBE, WITH STRAPS, EACH) is a urinary collection bag that includes straps which hold the bag securely to the body.

Manufacturers of urinary collection bags have notified the Pricing, Data Analysis and Coding (PDAC) Contractor that some collection bags do not contain straps. While manufacturers may offer these products without straps, Durable Medical Equipment, Prothestics, Orthotics and Supplies (DMEPOS) suppliers are reminded they MUST supply straps with the urinary drainage bag to the Medicare beneficiary.

Suppliers are reminded that A4358 includes both the drainage bag and straps. If the drainage bag from a particular manufacturer does not contain a leg strap, suppliers must provide a leg strap but should not bill using the miscellaneous code A4335 (INCONTINENCE SUPPLY; MISCELLANEOUS) and A5113 (LEG STRAP; LATEX, REPLACEMENT ONLY, PER SET) or A5114 (LEG STRAP; FOAM OR FABRIC, REPLACEMENT ONLY, PER SET).

Refer to the Local Coverage Determination (LCD) and Policy Article for Urological Supplies for coverage and HCPCS coding requirements.

All current DME products coded by the PDAC are found on the PDAC Web site on Durable Medical Equipment Coding System (DMECS), **https://www.dmepdac.com/dmecsapp/do/search**. For questions about correct coding, 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 Web site: **https://www.dmepdac.com/**

Coverage Reminder - Chiropractor Limitations (GEN)

DMEPOS suppliers are reminded that the *Social Security Act* (§1861(r)) restricts ordering by chiropractors to treatment by means of manual manipulation of the spine to correct a subluxation, provided such treatment is legal in the State where performed. Claims for any other item(s) or services prescribed by a chiropractor, including durable medical equipment, prosthetics, orthotics or supplies are denied as statutorily noncovered.

E0486 - Custom Fabricated Oral Appliance for OSA - Coding and Utilization Guidelines (GEN)

Code E0486 describes a custom fabricated oral appliance used for the treatment of obstructive sleep apnea.

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

Effective for claims submitted on or after September 01, 2011, the only products that may be billed using code E0486 are those that have undergone Coding Verification Review by the Pricing, Data Analysis, and Coding (PDAC) Contractor and that are listed in the DMECS Product Classification List on the PDAC Web site.

Questions concerning the coding of these products should be referred to the PDAC. For additional information about coverage, refer to the *Oral Appliances for the Treatment of Obstructive Sleep Apnea LCD and Policy Article*.

Glucose Monitor Supplies - Utilization Reminder (GEN)

Recent data analysis for Jurisdiction A has identified instances where beneficiaries have received supplies that exceed the policy's usual utilization amounts. The policy recognizes that there may be occasions when a beneficiary may require greater than expected amounts. There are specific requirements associated with the provision of higher than usual utilization amounts. Claims experience has shown that many suppliers lack the required information in their files to justify payment for high utilization. This article is intended to serve as a reminder of the utilization amounts for Glucose Supplies and some of the commonly overlooked requirements.

Usual utilization for the most common items is:

- Insulin treated group, indicated by the KX modifier, at 100 strips/lancets per month
- Non-insulin treated group, indicated with a KS modifier, at 100 strips/lancets per 3 months
- A spring-powered device for lancets (A4258) is 1 device per 6 months.

These amounts represent the usual maximum amount that most beneficiaries will need based upon typical testing frequencies.

In audits, suppliers often lack records documenting their monitoring of beneficiary utilization and any adjustments made to refill frequency of quantities shipped. The policy requires,

> "*Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering physicians that the atypical utilization is, in fact, warranted.*"

Another common deficiency noted is incomplete or missing prescriptions. All items billed require a detailed written order in the supplier's files before a claim is submitted. The order for home blood glucose monitors and/or diabetic testing supplies must include all of the following elements:

1. The item(s) to be dispensed;

2. The specific frequency of testing;
3. The treating physician's signature;
4. The date of the treating physician's signature;
5. A start date of the order - only required if the start date is different from the signature date.

An order that only states, "as needed" will result in those items being denied as not medically necessary.

A new order must be obtained when there is a change in the testing frequency.

Finally, the ICD-9 diagnosis code describing the condition that necessitates glucose testing must be included on each claim for the monitor, accessories and supplies.

Refer to the *Glucose Monitors LCD and related Policy Article* and the *Supplier Manual* for additional information.

LCD and Policy Article Revisions - Summary for March 03, 2011 (GEN)

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

Automatic External Defibrillators

LCD

Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Added: KF modifier
Revised: GA modifier

Policy Article

Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble statement
CODING GUIDELINES:
Added: KF modifier use information

Cold Therapy

LCD

Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Added: Code A9273

Policy Article

Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language

HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Intravenous Immune globulin

LCD
Revision History Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Preamble
Revised: "Medical necessity" changed to "reasonable and necessary"
HCPCS CODES:
Added: J1599
DOCUMENTATION REQUIREMENTS:
Added: J1599
Revised: Information required for NOC codes

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement

Lower Limb Prosthesis

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Functional level requirement for L5961
Changed functional level for L5978.
HCPCS CODES:
Added: L5961

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Added: Benefit Category Statement

Mechanical In-exsufflation Devices

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble
Replaced: "medically necessary" with "reasonable and necessary"
HCPCS CODES AND MODIFIERS:
Added: A7020
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 359.21

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement

CODING GUIDELINES:
Added: Bundling statement for A7020

Negative Pressure Wound Therapy Pumps

LCD

Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Preamble
Revised: "medically necessary" replaced with "reasonable and necessary"
HCPCS CODES AND MODIFIERS
Revised: GA narrative
DOCUMENTATION REQUIREMENTS:
Revised: "medically necessary" replaced with "reasonable and necessary"

Policy Article

Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added Benefit category statement

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article

Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Ostomy Supplies

LCD

Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: A4399, A4407, A4408

Policy Article

Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Oxygen and Oxygen Supplies

LCD

Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Noncoverage statement for E0446
Added: Clinical trial coverage for cluster headaches (CR7235)
Revised: Clarified sleep testing qualification using results that drop from baseline.
HCPCS CODES AND MODIFIERS:
Added: E0446

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble and coverage benefit statement
CODING GUIDELINES:
Added: Coding instructions for equipment used in a cluster headache clinical trial (CR7235)
BILLING INFORMATION:
Clarified: Monthly billing for contents

Pressure Reducing Support Surfaces - Group 1

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Pressure Reducing Support Surfaces - Group 2

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES (Effective 01/01/2007) :
Removed: Reference to E0180 as a possible code for a powered overlay

Pressure Reducing Support Surfaces - Group 3

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Refractive Lens

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Speech Generating Devices

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language

Transcutaneous Electrical Nerve Stimulators

LCD
Revision Effective Date: 01/01/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Added: Preamble
Revised: "medically necessary" replaced with "reasonable and necessary"
HCPCS CODES AND MODIFIERS:
Revised: GA modifier narrative
DOCUMENTATION REQUIREMENTS:
Revised: "medically necessary" replaced with "reasonable and necessary"

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement

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

LCD and Policy Article Revisions - Summary for April 21, 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.

Lower Limb Prosthesis

LCD
Revision Effective Date: 01/01/2011 (April publication)
DOCUMENTATION REQUIREMENTS:
Clarified instruction for submitting prosthetic claim for billed code for hip (L5961)

Policy Article
Revision Effective Date: 01/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Updated list of prostheses included in the payment to a SNF

Nebulizers

Policy Article

Revision Effective Date: 02/04/2011

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble language

Revised: Correct coding instructions for code G0333

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

LCD and Policy Article Revisions - Summary for May 12, 2011 (GEN)

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

Oral Anticancer Drugs

Policy Article

Revision Effective Date: June 1, 2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble language

Revised: Supply fee guidelines for additional billing of Q0511

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

Policy Article

Revision Effective Date: June 1, 2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Supply fee guidelines for additional billing of Q0511

Immunosuppressive Drugs

Policy Article

Revision Effective Date: 6/01/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble language

Revised: Supply fee guidelines for additional billing of Q0510, Q0511

Power Mobility Devices

LCD

Revision Effective Date: 06/01/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Denial statement for Group 2 POVs

Added: Denial statement for Group 4 PWCs

DOCUMENTATION

Deleted: KX modifier use with Group 4 PWCs

Revised: Requirements for the detailed product description

Added: Clarification of 7-element order requirements

Policy Article

Revision Effective Date: 06/01/2011

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Benefit category statement

Added: Statutory reference for 7-element order requirements

Removed: Noncoverage statement for Group 2 POVs and Group 4 PWCs.

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

LCD and Policy Article Revisions - Summary for May 26, 2011 (GEN)

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

Knee Orthoses

LCD

Revision Effective Date: 07/01/2011

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-9 codes 340.91 and 340.92 for L1832, L1843 - L1846

Oral Appliances for Obstructive Sleep Apnea

LCD

Revision Effective Date: 09/01/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Correct coding denial to reflect PDAC review requirement for E0486

Removed: References

Policy Article

Revision Effective Date: 09/01/2011

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble

Added: Benefit category statement

CODING GUIDELINES:

Added: PDAC review requirement for E0486

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.*

NDC for Capecitabine (Xeloda®) 500 mg. Dosage Form - European Formulation Blister Pack (DRU)

The Pricing, Data Analysis, and Coding Contractor (PDAC) has the new NDC for this preparation of capecitabine included in the NDC Crosswalk posted on **http://www.dmepdac.com**.

NDC number 00004-1101-75 for the European version of Xeloda 500 mg. dosage form in the blister pack is effective for claims with dates of service on or after 03/29/2011 received by the DME MAC on or after 05/09/2011.

Refer to the *Oral Anticancer Drug LCD and Policy article* for additional information.

Nebulizer Drugs Units of Service (UOS) (DRU)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are aware of trends in billing discrepancies for nebulizer drugs. This article serves as a tool to assist DMEPOS suppliers to correctly calculate the units of service for nebulizer drugs when billing.

Drug Name	HCPCS	Unit of Service(UOS)	Maximum/month	Maximum UOS/month
Acetylcysteine	J7608	per 1 gram	74 grams/month	74
Albuterol	J7611, J7613	per 1 mg	465 mg/month**	465
Albuterol/Ipratropium combination	J7620	up to 2.5 mg albuterol and 0.5 mg of ipratropium - 3.0mg total - 1 vial	558 mg total/month - 186 vials**	186
Arformoterol	J7605	15 mcg	930 mcg/month	62
Budesonide	J7626	up to 0.5 mg - 1 vial	31 mg/month	62
Cromolyn sodium	J7631	per 10 mg	2480 mg/month	248
Dornase alpha	J7639	per 1 mg	78 mg/month	78
Formoterol	J7606	20 mcg	1240 mcg/month	62
Ipratropium bromide	J7644	per 1 mg	93 mg/month	93
Levalbuterol	J7612, J7614	per 0.5 mg	232.5 mg/month **	465
Metaproterenol	J7669	per 10 mg	2800 mg/month **	280
Pentamidine	J2545	per 300 mg	300 mg/month	1
Treprostinil	J7686	1.74 mg - 1 ampule/vial	31 ampules/vials month	31
Sterile saline or water	A4216, A4218	10 ml - 1 unit	560 ml/month	56
Distilled water, sterile water, or sterile saline in large volume nebulizer	A4217, A7018	500 ml	18,000 ml - 18 liters/month	36

**When albuterol, levalbuterol, or metaproterenol are prescribed as rescue/supplemental medication for patients who are taking formoterol or arformoterol, the maximum milligrams/month that are reasonably billed are:

Drug Name	HCPCS	Unit of Service	Maximum milligrams/month	Maximum UOS/month
Albuterol	J7611, J7613	1 mg	78 mg/month	78
Albuterol/Ipratropium combination	J7620	up to 2.5 mg albuterol and 0.5 mg of ipratropium - 3.0 mg total - 1 vial	93 mg/month - 31 vials	31
Levalbuterol	J7612, J7614	0.5 mg	39 mg/month	78
Metaproterenol	J7669	Per 10 mg	470 mg/month	47

The billing unit of service for inhalation drug codes varies. Suppliers must be sure that they use the correct billing unit of the code when calculating the number of units of service to enter on the claim. Listed below are examples of some of the more common errors identified when billing for nebulizer drugs:

- Code J7620 is used for an FDA-approved combination of albuterol and ipratropium which contains 3.0 mg of albuterol sulfate, which is 2.5 mg of albuterol base and 0.5 mg of ipratropium bromide in each unit dose vial. For these products, 1 unit of service of J7620 equals 1 unit dose vial.

- For code J7626 and J7627 (budesonide, unit dose) bill one unit of service for each vial dispensed, regardless of whether a 0.25 mg vial or a 0.5 mg vial is dispensed. If the vial dispensed is a 1.0 mg vial suppliers must bill 2 units of service for each vial dispensed.

For additional information, suppliers should refer to the *Nebulizers Local Coverage Determination (LCD) and Policy Article (PA)*.

Reasonable Useful Lifetime and Duplicate Items - Billing Reminder (GEN)

Medicare defines a Reasonable Useful Lifetime (RUL) for many items. RUL is the expected minimum lifespan for the item. It starts on the initial date of service and runs for the defined length of time. The default RUL for durable medical equipment is statutorily set at 5 years. RUL is also applied to other non-DME items such as orthoses and prostheses. RUL is not applied to supply items.

If a same or similar item is provided during the RUL of an item already in the beneficiary's possession, it will be denied as same/similar or duplicate.

Suppliers are encouraged to inquire about the beneficiary's history of similar items.

Refer to the *Supplier Manual* for additional information about RUL and duplicate items.

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

Historical Review Results
This is the first DME MAC A Medical Review probe for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm). 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 B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm). These findings cover claims with paid dates from November 2010 through January 2011.

The review involved prepayment complex medical review of 98 claims submitted by 36 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 16 (16%) of the claims. For the remaining 82 claims, 11 claims were allowed and 71 were denied resulting in a claim denial rate of 87%. 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 86.7%.

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 Medical Necessity Documentation:

- 52% of the denied claims were missing the clinical documentation to support medical necessity.
- 3% of the denied claims had insufficient clinical documentation to justify the need for enteral nutrition or the enteral infusion pump as defined in the LCD.

Detailed Written Order issues:

- 28% of the denied claims had missing detailed written orders.
- 10% of the denied claims had an incomplete detailed written order.
- 7% of the denied claims had orders that were signed and dated by the prescribing physician after the submission date of the claim.

DME MAC Informational Form (DIF) Discrepancies:

- 11% of the denied claims did not have the HCPCS pump code documented on the DIF.
- 4% of the denied claims had a DIF dated after the claim submission date.
- 3% of the denied claims had an incomplete or missing DIF.

Delivery Issues:

- 1 claim had items listed that were different than the items delivered.

Suppliers are reminded that proper documentation includes:

- Detailed written physician orders with the appropriate date.
- A completed DIF must be submitted with the initial claim and include appropriate items and date.
- Clinical documentation that justifies coverage for both the enteral nutrition and the enteral infusion pump.

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 delivery ticket, which validates that the beneficiary received the items that were billed, a completed DIF and limited clinical documentation.

Missing: The detailed written physician's order was not submitted. This is a requirement (*Medicare Program Integrity Manual*, Publication 100-08, Section 5.2.3). The clinical documentation is insufficient to support LCD coverage criteria for enteral nutrition. These criteria must first be met before supplies and/or accessories can be allowed. There is also no evidence in the clinical documentation as to why the beneficiary is in need of an enteral pump.

Example 2:

Received: The supplier submitted the following: a detailed written physician's order for items billed, insufficient delivery information, the appropriate completed DIF and clinical documentation from the prescribing physician as well as documentation from other clinicians supporting the LCD criteria for enteral nutrition and the enteral pump.

Missing: The detailed written physician's order is dated - 1/22/11 which is dated after the DOS of 9/8/10. This does not meet the criteria for medical necessity per the LCD L5041, therefore cannot be accepted as a valid order. Delivery information did not reflect all of the items billed on the claim which implies the beneficiary did not receive all of the items that were ordered by the physician and billed to Medicare.

Example 3:

Received: The supplier submitted the following: the detailed written physician's order, medical record documentation supporting the medical necessity for enteral nutrition and the enteral pump, and appropriate proof of delivery for items ordered by the physician and billed by the supplier.

Missing: The DIF was not submitted as required by the LCD (L5041) and *Medicare Program Integrity Manual*, Publication 100-08, Section 5.3.

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** (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**)
- **DME MAC Jurisdiction A Supplier Manual** (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements
- **CERT Physician Letter - Enteral Nutrition** (**http://www.medicarenhic.com/dme/CERT/EN_phy_letter_doc.pdf**)
- **Monthly CERT Error examples** (**http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml**)
- **Enteral Nutrition Units of Service Calculator** (**http://www.medicarenhic.com/dme/self-service.shtml**)
- **Frequently Asked Questions** (**http://www.medicarenhic.com/faq_results.asp?categories=DME**) (search word enteral)
- **Enteral Nutrition Supply Kits - Coverage Reminder** (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_enteral-kits.pdf**)

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

Historical Review Results
DME MAC A Medical Review continues to review A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Tracheostomy) based on the results of previous probe findings. The previous probe resulted in a 66.86% Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has completed the prepayment probe review of claims for A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Tracheostomy). These findings cover claims with service dates primarily from November 2010 through January 2011.

The review involved prepayment complex medical review of 113 claims submitted by 55 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 19 (17%) of the claims. For the remaining 94 claims, 35 claims were allowed and 59 were denied resulting in a claim denial rate of 62.7%. 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 (CDR) of 61%.

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

Medical Necessity Documentation Issues

- 53% of the denied claims were missing any clinical information to support medical necessity. (No medical records of any sort submitted.)
- 32% of the denied claims had insufficient clinical documentation. The medical record information submitted was *insufficient* to show that the coverage criteria listed in the local coverage determination (LCD) were met. Examples of insufficient clinical documentation received include:
  - A flow sheet without the patient's name , date of birth, or diagnosis
  - Illegible medical records
  - Medical records without any current documentation to show that the patient is still being seen by the physician or other qualified medical professional

Diagnosis

- 10% of the claims were denied for not including a payable diagnosis. Examples include:
  - No mention of a payable diagnosis in the medical records submitted

Proof of Delivery

- 36% of the denied claims had delivery documentation issues. Examples include:
  - Missing delivery tickets (no proof patient ever received supplies)
  - Missing supply list (no itemization of what patient received)

Prescription Issue

- 2% of the denied claims had the initial dispensing order dated after the delivery date

Claim Examples

As an additional educational effort, 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 tracheostomy supply claims.

Example 1

Received: The supplier submitted a claim that included the patient's name, diagnosis, a physician order that was signed and dated, and a delivery ticket.

Missing: Medical records were not included that would support the medical necessity of the tracheostomy supplies. Also missing from the delivery ticket was a listing of the supplies delivered to the patient.

Example 2:

Received: The supplier submitted medical records, the physician's order that was signed and dated, delivery ticket, and invoice of supplies.

Missing: All requested documentation was submitted. However a payable diagnosis was not included on the claim or within the medical records. An appropriate medical diagnosis is necessary to determine the medical need of the tracheostomy supplies.

Example 3:

Received: The supplier submitted all of the required documentation, medical records, payable diagnosis, delivery ticket and invoice.

Missing: The initial dispensing order was dated after the date of service on the claim.

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Tracheostomy).

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 tracheostomy care supply 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:

- **Tracheostomy Care Supplies (L11536) LCD** and **Tracheostomy Care Supplies - Policy Article** - September 2009 (A33771) (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**)

- **DME MAC Jurisdiction A Supplier Manual** (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) (Reference Chapter 10 - Durable Medical Equipment) Documentation Requirements section for additional information regarding coverage and documentation requirements.

- **CERT Physician Letter - Documentation** (**http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_doc.pdf**)

- **Results of Widespread Prepayment Review of Claims for HCPCS Codes A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Patients)** (Posted on August 27, 2010) (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/082710_trach.pdf**)

Results of Widespread Prepayment Review for E0570 (Nebulizer, with Compressor) (L11499) (SPE)

Historical Review Results
DME MAC A Medical Review continues to review Nebulizers, with Compressor, based on the results of previous quarterly findings. The previous quarterly findings covered the period of July 2010 through October 2010 service dates and resulted in a 68.3% Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has completed the prepayment probe review of claims for E0570 (Nebulizer, with Compressor). These findings cover claims with paid dates primarily from November 2010 through February 2011.

The review involved prepayment complex medical review of 294 claims submitted by 183 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 73 (25%) of the claims. For the remaining 221 claims, 76 claims were allowed and 145 were denied resulting in a claim denial rate of 65.6%. 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 (CDR) of 67.2%.

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:

Documentation Issues:

- 61%of the denied claims were missing any clinical information to support medical necessity. No medical records of any sort submitted.
- 24% of the denied claims had insufficient clinical documentation. The documentation submitted focused on other medical issues unrelated to nebulizers.

Detailed Written Order Issues:

- 7% of the denied claims had incomplete detailed written orders due to missing physician signature.
- 4% of the denied claims had incomplete detailed written orders due to an incomplete description.
- 2 % of the denied clams had incomplete detailed written orders due to no date on the order.
- 2% of the denied claims were missing the detailed written order.

Proof of Delivery Issues:

- 5% of the denied claims were missing proof of delivery.

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

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

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 nebulizer claims:

Example 1:

Received: Detailed written order with patient name, legible signature and date of legible signature.

Missing: Clinical documentation that demonstrates need and proper use of equipment, as well as proof of delivery with beneficiary signature.

Example 2:

Received: Delivery ticket with the beneficiary signature and date. A physician letter confirming use of equipment.

Missing: Detailed order with the patient's name, description of the item to be dispensed, physician's legible signature, date of physician signature; clinical records supporting the need and use of the equipment and appropriate diagnosis as required by the local coverage determination (LCD).

Example 3:

Received: Detailed written order with patient name and legible signature, date of legible signature and delivery slip with beneficiary signature.

Missing: Supplier did not include any medical records reflecting the need for the nebulizer equipment.

Next Step
Based on the results of this prepayment review, DME MAC A will continue to review claims for E0570 (Nebulizer, with Compressor).

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 nebulizer 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:

- **Nebulizers (L11499) LCD** (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**)
- **Nebulizers - Policy Article - Effective February 2011(A24944)** (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**)
- **DME MAC Jurisdiction A Supplier Manual** (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
- **CERT Physician Letter - Nebulizers Monthly CERT Error examples** (**http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml**)
- **Frequently Asked Questions** (**http://www.medicarenhic.com/faq_results.asp?categories=DME**) (search word nebulizer)

Results of Widespread Prepayment Review for Home Blood Glucose Monitor Supplies Documentation Compliance Review (GEN)

The DME MAC Jurisdiction A conducted a prepayment review of claims for Home Blood Glucose Monitor Supplies. The review was initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) Contractor for missing and/or incomplete documentation.

This review was for claims with process dates from November 2010 through January 2011. The specific documentation requested and reviewed consisted of:

1. The detailed written order
2. Records of beneficiary utilization and testing frequency
3. Supplier records of refill request
4. Proof of Delivery
5. Documentation that the beneficiary (or the beneficiary's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices
6. Documentation that the beneficiary (or the beneficiary's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control

Review Results
The review involved a Documentation Compliance Review (DCR) of 995 claims. Responses to the Additional Documentation Request (ADR) were not received for 701 (70%) of the claims. 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. For the 249 claims for which ADR responses were received, 31 claims (12.5%) were approved and 218 (87.5%) were denied.

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

Detailed Written Order issues
19% of the denied claims were missing the detailed written order.
26% of the denied claims had incomplete detailed written orders lacking one or more of the required items

Supplier records of refill request
63% of the denied claims were missing the supplier record of the refill request

Proof of Delivery
23% of the denied claims were missing proof of delivery
1% of the denied claims had incomplete proof of delivery

Documentation of training
48% of the denied claims were missing documentation that the beneficiary (or the beneficiary's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices

Next Step
Based on the results of this prepayment review, DME MAC A will continue to conduct a DCR for Home Blood Glucose Monitor Supplies.

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

- **Glucose Monitors (L11530) LCD** (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**)
- **DME MAC Jurisdiction A Supplier Manual** (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
- **CERT Physician Letter - Glucose Monitor & Supplies** (**http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_glucose.pdf**)
- **February 2011 CERT Errors** (**http://www.medicarenhic.com/dme/articles/032511_CERT-Errors.pdf**)
- **Glucose Monitor Billing tutorial** (**http://www.medicarenhic.com/dme/dme-eduonline.shtml#tutorials**)
- **Glucose Testing Supplies: Complying with Documentation & Coverage Requirements** (**http://www.cms.gov/MLNProducts/downloads/GlucSup_DocCvge_FactSheet_ICN905104.pdf**)
- **Frequently Asked Questions** (**http://www.medicarenhic.com/faq_results.asp?categories=DME**) (search word glucose)

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 July 2010 through September 2010 and resulted in a 71% 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 service dates primarily from October 2010 through December 2010.

The review involved prepayment complex medical review of 183 claims submitted by 118 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 62 (34%) of the claims. For the remaining 121 claims, 36 claims were allowed and 85 were denied resulting in a claim denial rate of 70.2%. 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 71.5%.

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

Clinical Documentation Issues (72%)
- 45% of the denied claims were missing any clinical information to support medical necessity. No medical records of any sort submitted.
- 27% of the denied claims had insufficient medical records submitted. The documentation submitted focused on other medical issues unrelated to oxygen.

Detail Written Order Issues (35%)
- 20% of the denied claims had incomplete detail written orders, missing the rate (LPM) of oxygen prescribed.
- 15 % of the denied claims did not include a physician order.

Certificate of Medical Necessity (CMN) Issues (7%)
- 4% of the denied claims were missing a required CMN.
- 2 % of the denied claims included an incorrect CMN form submitted.

- 1% of the denied claims had a CMN which was incomplete.

Delivery Issues

- 1% of the denied claims had a delivery ticket issue.

Suppliers are reminded that proper documentation includes:

- A Complete Physician Order: Rate- LPM, Acceptable Signature, Date.
- Medical Documentation should include the following :
  - treating physician determination that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
  - the patient's blood gas study meets the criteria stated below, and
  - the qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory service, and
  - the qualifying blood gas study was obtained under the conditions stated in the LCD, and
  - alternative treatment measures have been tried or considered and deemed clinically ineffective.
- A complete Initial , Recertification or Revised CMN submitted within the appropriate guideline based on the patient's original group criteria being met
- Valid delivery ticket.

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 oxygen therapy claims:

Example 1:

Documentation was received but patient did not meet criteria for Group I:

Received: treating physician order, initial CMN, delivery ticket, beneficiary authorization, Nocturnal sleep study, multiple clinical physician treating notes.

Missing: treating physician clinical notes to indicate need for home oxygen therapy; assessment only includes / prescribes hand held inhalers. (LCD L11468 - Criteria for home oxygen therapy).

Example 2:

Documentation was received but lacking supporting documentation:

Received: verbal order, delivery ticket, initial CMN, physician order, physician visit dated 2/16/10; initial CMN dated 2/27/10.

Missing: test results for meeting Group I criteria (how obtained - only an order indicating 87% on Room Air). Physician visit dated 2/16/10 does not indicate patient's need for home oxygen therapy. (LCD L11468 - Criteria for home oxygen therapy).

Example 3:

Documentation was received but patient did not meet criteria for Group I as indicated on Certificate of Medical Necessity Form:

Received: Delivery ticket, beneficiary authorization, initial CMN, Recert CMN, intake verbal order, physician order, beneficiary authorization, MD visit 6/8/10 with appropriate diagnosis with pulse oximetry level listed at 90% on Room Air at rest and exertion, clinical note documents patient's use of Ventolin and Spiriva.

Missing: treating physician clinical notes and testing to support need for home oxygen therapy and oxygen saturation level listed on initial and recert CMN for Group I. (LCDL11468 Group I criteria).

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims for **Oxygen and Oxygen Equipment** (HCPCS Codes 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 Home Oxygen Therapy 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:

- **Oxygen and Oxygen Equipment (L11468) LCD** (**http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**)
- **DME MAC Jurisdiction A Supplier Manual** (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
- **January 2011 CERT Errors** (**http://www.medicarenhic.com/dme/articles/021811_CERT-Errors.pdf**)
- **CERT Physician Letter - Oxygen & Supplies** (**http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_oxy.pdf**)
- **Frequently Asked Questions** (**http://www.medicarenhic.com/faq_results.asp?categories=DME**) (search word oxygen)
- **Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439)** (Posted November 5, 2010, Posted June 9, 2010) (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/110510_O2.pdf**)

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

Historical Review Results
DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from July 01, 2010 through September 30, 2010 and resulted in a 62.6% Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS K0823). These findings cover claims with paid dates primarily from October 2010 through December 2010. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 779 claims submitted by 251 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 213 (27%) of the claims. Of the 566 claims for which responses were received, 221 claims were allowed and 345 were denied resulting in a claim denial rate of 61%. 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 52.4%.

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

- 10% of the denied claims did not show evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair (PWC).
- 12% of the denied claims did not have a valid delivery ticket.
- 12% claims did not contain a 7 element order or the 7 element order was incomplete per LCD guidelines.
- 60% of the denied claims did not contain the clinical documentation to justify medical necessity. Examples include:
  - Documentation did not include clinical support from the ordering clinician's Face to Face (F2F) Mobility Exam to demonstrate that a patient is prevented from accomplishing mobility-related activities of daily living (MRADLs) due to physical mobility deficits.
  - Medical records do not always contain specific reasons why the patient is at risk for morbidity or mortality while attempting to perform MRADLs, i.e., fall risk.

- F2F exams consistently did not include a comprehensive medical exam that cites the patient's specific mobility limitations, i.e., upper and lower body strength, range of motion, coordination, pain, physical deformities and physical endurance.
- Clinical documentation often is insufficient as it does not address a historical perspective of the patient's mobility issues and present needs.

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 K0823 claims:

Example 1:

Received: The ordering clinician submitted a 7 element order that included the patient's name, item to be ordered (PWC), clinician's signature and date written.

Missing: Ordering clinician did not include the date of the F2F exam, pertinent diagnosis, the length of need of the item and the order was not stamp dated or an equivalent to verify that the supplier received the order within 45 days of the F2F exam.

Example 2:

Received: Ordering clinician submitted a clinical note dated the day of the reported date of the F2F exam, but did not indicate that the exam was for the purpose of a F2F mobility examination. The notes did not list objective findings that supported the patient had mobility limitations and that the mobility limitations could not be corrected by other mobility devices such as a walker or manual wheelchair. Upper and lower body strength was described as "weak", but no objective measurements were given. The clinician reported that the patient did not have the ability to self propel a manual wheelchair, but did not give the specific reasons that prevented the patient's ability to propel a manual wheelchair. Clinician did not give a historical prospective on when the mobility limitation started and how it has progressed.

Missing: F2F evaluation was missing specific information regarding upper and lower body strength, ROM, and ability to attend to and complete MRADLs. Documentation was insufficient as it did not objectively address mobility limitations and provide a clear picture of the patient's mobility deficits. Sufficient objective measurements were not provided.

Example 3:

Received: Ordering clinician submitted an exam which he did report was for a "mobility assessment" and made some general statements as follows: 1-Clinician stated the patient could ambulate around the home and prepare meals. 2-Clinician reports she has had a trial of a PWC. 3-Clinician reports patient needs to get out and about. 4-Clinician reported that the appropriate paperwork was completed for a PWC. However, there was no specific clinical documentation provided to support medical necessity for a PWC or a comprehensive medical exam.

Missing: Documentation did not include clinical documentation from the ordering clinician that a PWC is medically necessary. There was no documentation that indicated if the patient could benefit from an alternate type of mobility device. There were no objective clinical measurements documented to explain how severe the patient's mobility deficit is. The clinician reports the patient is ambulating around the house and attending to MRADLs. The clinician needs to explain the patient's mobility abilities and if she requires mobility devices or assists.

Next Step
Based on the results of this prepayment review, DME MAC A will continue to review claims billed with HCPCS K0823.

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 K0823 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:

- **Power Mobility Devices (L21271) LCD (http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml)**

- November 05, 2009 educational article **Power Mobility Devices - 7-Element Order** (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf**)

- January 11, 2008 educational article **Power Mobility Devices Billing Reminder** (**http://www.medicarenhic.com/dme/articles/011108_pmd.pdf**)

- **DME MAC Jurisdiction A Supplier Manual** (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements).

- Previous articles on results of prepayment reviews: **MR bulletins** (**http://www.medicarenhic.com/dme/medical_review/mr_bulletin_current.shtml**)

- **Frequently Asked Questions** (**http://www.medicarenhic.com/faq_results.asp?categories=DME**) (search word PMD)

Upgrades to Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) (MOB)

Recent revisions to the Power Mobility LCD eliminating Least Costly Medically Necessary Alternative classified the denials for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) as statutorily noncovered. This determination caused the unintended consequence of making these items ineligible for the Advanced Beneficiary Notice (ABN) upgrade process. The LCD and Policy Article are being revised to indicate that Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are considered durable medical equipment but are not reasonable and necessary. This change will be effective for dates of service on or after June 01, 2011.

In addition to capabilities that allow Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) to be used in the home, they also have certain performance characteristics that are not reasonable and necessary for use in the home such as (not all-inclusive):

- robust frames
- motors with increased torque/power
- suspensions with enhanced vibration-dampening or obstacle climbing capabilities

The revised Power Mobility Devices LCD and related Policy Article will reflect that claims for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) will be denied as not reasonable and necessary. As a result, Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are eligible for the ABN upgrade provisions as set out in the recently published bulletin article on the use of upgrade modifiers as a result of changes due to elimination of least costly alternative.

Refer to the *LCD*, *Policy Article*, and *Supplier Manual* for additional information on upgrades and Power Mobility devices.

The *Power Mobility Devices LCD and Policy Article* revisions will be published in the near future.

Urological Supplies - Extension of A4353 Coding Guideline - Effective Date to March 20, 2011 (GEN)

The December 2010 update to the Urological Supplies LCD and Policy Article contained a revision of the coding guidelines for A4353 (INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES) with an effective date of 02/04/2011. Based upon questions about the correct application of the guideline, the instruction was revised to clarify the correct coding instruction. This revision was released in early February and retained the 02/04/2011 effective date. We have recently become aware that some suppliers were not able to meet this date and remain in compliance with the coding guideline.

We are sensitive to the ongoing needs of Medicare beneficiaries and do not wish to impose an undue burden upon them should a supplier be unable to ship A4353 supplies timely. With this consideration, the DME MAC medical directors will extend the effective

date of the A4353 coding decision to claims with dates of service on or before March 20, 2011, in effect granting an additional 45 days notice from the original effective date of February 04, 2011. For claims with dates of service on or after March 21, 2011 items provided and billed under HCPCS code A4353 must be in compliance with the coding guidelines described in the Policy Article for Urological Supplies.

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

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. The detailed written order
2. Certificate of Medical Necessity (CMN)
3. Copy of the laboratory result for the arterial blood gas PO2 and/or oxygen saturation test value reported on the CMN
4. Documentation of a physician office visit prior to the initial date of service
5. 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.

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

DME MAC A will be initiating a widespread prepayment probe of claims for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided.

K3 - Lower extremity prosthesis functional Level 3 - Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) contractor.

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

Documentation should include the following per the Local Coverage Determination (LCD) for Lower Limb Prostheses (L11464):

1. Physician order for the item. Include both the dispensing order and the detailed written order.

2. Information from the medical record that demonstrates the reasonable and necessary coverage criteria for the item(s) are met. Include detailed information about the following:
    a. The determination of the beneficiary's functional status (K0-K4 level)
    b. Factors that justify the selection of the components provided

3. Proof of delivery with name, address and signature of the beneficiary; the item(s) provided; date of delivery; and supplier identification.

4. Invoice(s) for the item(s) provided including manufacturer name and model number.

5. Any other pertinent information that would justify payment for the item(s) provided.

6. Advanced Beneficiary Notice (ABN) if one was obtained, this must be submitted with the above requested documentation.

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

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy article. Suppliers can review the *LCD for Lower Limb Prostheses (L11464)* on the NHIC Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

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

First 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 January through March 2011, are provided in the following table.

Please 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	152,276	The procedure code, modifier, or procedure code and modifier combination is invalid.
C044 - Subscriber Primary ID Invalid	39,527	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
B108 - Billing provider not authorized for submitter	30,888	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C171 - Capped Rental - Modifier Missing	28,339	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)	27,632	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	24,618	There is no link between the NPI that was submitted and a PTAN/NSC.
C095 - Diagnosis Code Invalid - Pointer 1	23,818	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
C179 - Service From/To Dates Not Equal	16,567	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.
C180 - Service Date Greater than Receipt Date	14,370	The service start/from date is greater than the date this claim was received.
C183 - Required Note Missing	13,234	The narrative information is missing. The procedure code submitted requires narrative information.

First Quarter 2011 - Top Return/Reject Denials

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the first 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 January through March 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.	30,899
CO 182 N56 Procedure modifier was invalid on the date of service.	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	11,482
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,108

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
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).	2,378
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.	1,414
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,212
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).	788
CO 16 M51, N225, N29 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	644
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.	642
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.	595

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that all the required information is on each claim. DME MAC Jurisdiction A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above tables and share it with your colleagues!

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

Date: Wednesday, June 22, 2011
Time: 10:30 AM - 12:00 PM EST

Call Details
During this call, the Provider Outreach & Education Team will provide details regarding recent Updates to the Medicare program. An operator assisted question and answer period will follow. The call will begin promptly at 10:30 AM EST and may last up to one hour and thirty minutes.

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

Registration

To participate, webinar registration is required. After your registration is complete, you will receive a confirmation email 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/926469706**

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

Ask-the-Contractor Teleconference (ACT) Q&A - March 23, 2011 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Wednesday, March 23, 2011 as a teleconference / webinar on the topic of Elimination of Payment Determinations Based on Least Costly Alternative (LCA). A presentation was provided followed by an open Q&A session.

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

Q1: **Is there a specific modifier that is needed to indicate that a special enteral formula (B4149, B4153-B4157, B4161, and B4162) meets the applicable medical necessity criteria?**

A1: No. There is not a specific modifier that is used for billing special enteral formulas to indicate medical necessity is met; however, the medical necessity for special enteral formulas must be justified in each patient and be well documented in the patient's medical record. If the medical record does not document why that item is medically necessary, it will be denied as not reasonable and necessary.

Q2: **Another DME MAC Jurisdiction recently published a clarification article that included information regarding a K0831 power wheelchair (PWC) not being eligible for an upgrade. If we provide a K0831 to the customer but the customer only qualifies for a K0823 can we bill the K0831 as an upgrade?**

A2: No. An upgrade is not applicable in this situation. If a PWC with a seat elevator (K0830, K0831) is provided, it will be denied as noncovered because the seat elevator option is statutorily excluded from coverage. As a result, if the patient elects to rent or purchase the statutorily noncovered PWC instead of the reasonable and necessary PWC no Medicare reimbursement will be made for anything.

Note: *An ABN is not necessary to provoke a patient liability for a statutorily noncovered item.*

Q3: **How many claim lines are necessary to submit a claim for a physician ordered total electric hospital bed (E0265) that will be provided as a free upgrade?**

A3: You must submit the claim with one claim line to include the HCPCS code for the non-upgraded item that is covered based on the LCD. The GL modifier must be added in addition to all other applicable medical necessity (KX) and capped rental modifiers (RR, KH, KI, or KJ). The HCPCS code for the upgraded item is not submitted on the claim; however, the claim must include narrative detail in Item 19 or the NTE segment to include the make/model of the dispensed item and the reason this item is considered an upgrade.

Example:
Line #1 E0260RRKHKXGL

Q4: **Are statutorily noncovered items eligible to be provided as an upgrade?**

A4: No. Items that are statutorily excluded from coverage cannot be provided as an upgrade.

Q5: **Which item (covered item or upgraded item) needs to be submitted with the GL modifier?**

A5: The GL modifier is appended to the HCPCS code for the item that is covered based on the LCD but only in situations where the supplier wants to provide the upgraded item without any additional charge to the beneficiary and has not obtained an ABN.

Q6: **Is there an educational article specific to PMDs and the elimination of LCA that was published by Jurisdiction A DME MAC?**

A6: No. Not currently. However, Jurisdiction A does have a specific web page at **http://www.medicarenhic.com/dme/ELCA.shtml** which includes other references related to the elimination of LCA.

Q7: **Does the elimination of LCA apply to breast prostheses and mastectomy bras?**

A7: Elimination of LCA applies to L8031 (breast prostheses, silicone or equal, with integral adhesive) and L8035 (custom fabricated breast prosthesis). It does not apply to mastectomy bras.

Q8: **Do I still need to bill both E0265 and E0260 if I want to provide an upgrade and charge the beneficiary?**

A8: Yes. If you elect to charge the beneficiary for the upgrade, you must first obtain an ABN. There will be two claim lines. The first claim line must include the HCPCS code for the item that was provided as the upgrade and the GA modifier if you have obtained an ABN. The second claim line must include the HCPCS code for the item that is covered based on the LCD and the GK modifier.

Note: *Additional modifiers (i.e. RR, KH, KI, KJ, KX, etc.) may be applicable and must be billed accordingly. This may include competitive bidding modifiers as well.*

Example:
Line #1 E0265RRKHGA
Line #2 E0260RRKHKXGK

Q9: **If an E0260 is the reasonable and necessary item but the E0265 was provided as the free upgrade, which of the two HCPCS codes would actually be submitted on the claim and require the GL modifier?**

A9: The E0260 would be submitted on the claim and include the GL modifier.

Q10: **How are monthly rental payments broken down for standard power wheelchairs affected by the elimination of lump sum payment that was effective for items furnished on or after January 01, 2011?**

A10: Effective for claims with dates of service on or after January 01, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule is revised to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly rental method and 6 percent (instead of 7.5 percent) for each of the remaining rental months 4 through 13.

These changes do not apply to rented power-driven wheelchairs for which the date of service for the initial rental month is prior to January 01, 2011. For these items, payment for rental claims with dates of service on or after January 01, 2011, will continue to be based on 10 percent of the purchase price for rental months 2 and 3 and 7.5 percent of the purchase price for rental months 4 through 13.

Note: *The elimination of lump sum payment does not apply to standard power wheelchairs furnished to beneficiaries in the nine competitive bidding areas (CBAs) of Round 1 Rebid of the DMEPOS competitive bidding program with dates of service January 01, 2011 thru December 31, 2013.*

Q11: How does the elimination of LCA impact the ability for patients to upgrade items?

A11: A patient still has the option to upgrade as appropriate. Suppliers can receive partial payment at the time of initial determination for items that were previously paid based on an LCA determination but only if the supplier elects to bill as an upgrade for an eligible item.

Q12: Does the elimination of LCA apply to CPAP vs. BiPAP?

A12: Elimination of LCA applies to bi-level without backup (E0470) and bi-level with backup used for OSA (E0471).

Q13: Where is medical necessity information located on the DME MAC A Web site?

A13: Specified medical necessity information is available in each applicable LCD located in the Medical Review section of the DME MAC A Web site at: **http://www.medicarenhic.com/dme/medical_review/mr_index.shtml**

Q14: Can a supplier still provide Group 4 PWCs (K0868-K0886) as upgrades now that the elimination of LCA has been implemented?

A14: Current policy language regarding Group 2 POVs and Group 4 PWCs is under review. An updated response will be provided upon completion.

Q15: What is the proper way to bill an upgrade for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886)?

A15: Current policy language regarding Group 2 POVs and Group 4 PWCs is under review. An updated response will be provided upon completion.

Q16: If we only stock E0265 total electric hospital beds what upgrade modifiers would apply and how many claim lines are submitted in order to receive the proper payment?

A16: One claim line must be submitted with GL modifier appended to the HCPCS code for the reasonable and necessary item in which the patient qualifies for according to the LCD medical necessity criteria.

Q17: Are pumps for subcutaneous immune globulin (SCIG) products affected by the elimination of LCA? If so, can we bill an E0781 with an upgrade modifier?

A17: Yes. Pumps used for subcutaneous immune globulin products are affected by the elimination of LCA. Since the E0779 infusion pump is the only pump covered by Medicare for the administration of subcutaneous immune globulin if an E0781pump is provided instead, it will be denied as not reasonable and necessary. An upgrade can be billed in this situation but the upgrade modifier would only be added to HCPCS code E0781 in a two claim line upgrade situation. If there is only one claim line for a free upgrade then the E0781 would not be submitted on the claim.

Q18: Is there any way to document patient need for a total electric hospital bed and be paid the full amount?

A18: No. A total electric hospital bed (E0265, E0266, E0296, and E0297) is not covered; the height adjustment feature is a convenience feature. Total electric beds will be denied as not reasonable and necessary.

Q19: What type of medical necessity documentation should be on file for specialty enteral formulas?

A19: Special nutrient formulas, HCPCS codes B4149, B4153-B4157, B4161, and B4162, are produced to meet unique nutrient needs for specific disease conditions. The patient's medical record must adequately document the specific condition that warrants the use and the need of the special nutrient. This would be in addition to the documentation that would support the basic enteral nutrition coverage criteria.

Q20: **If we provide a Group 4 PWC as an upgrade to a Medicare patient and they qualify for a Group 3 PWC how would the claim be billed?**

A20: Current policy language regarding Group 2 POVs and Group 4 PWCs is under review. An updated response will be provided upon completion.

Q21: **Is it acceptable for the supplier to provide a K0831 as an upgrade if they have obtained an ABN?**

A21: No. An upgrade is not applicable in this situation. If a PWC with a seat elevator (K0830, K0831) is provided, it will be denied as noncovered because the seat elevator option is statutorily excluded from coverage. As a result, if the patient elects to rent or purchase the statutorily noncovered PWC instead of the reasonable and necessary PWC no Medicare reimbursement will be made for anything.

Billing Reminder for Replacement Orthopedic Footwear (O&P)

When billing for replacement of Orthopedic Footwear that is an integral part of a leg brace it is necessary for the following information to be documented in the NTE 2300 or NTE 2400 segment of the electronic claim or Item 19 of a paper claim:

- Indication that the shoe being replaced is part of a brace
- The HCPCS code for the brace

For example: "**shoe being replaced is part of a brace (HCPCS L1900)**"

All other applicable modifiers must be appended to the HCPCS code including:

The KX or GY modifiers: When billing for a shoe that is an integral part of a leg brace or for related modifications, inserts, heel/sole replacements or shoe transfer, a KX modifier must be added to the code. If the shoe or related item is not an integral part of a leg brace, the KX modifier must not be used and the GY modifier must be appended.

The right (RT) and/or left (LT) modifiers must also be used with all footwear HCPCS codes in the *Orthopedic Footwear LCD*. When the same code for bilateral items (left and right) is billed on the same date of service; bill for both items on the same claim line using the RTLT modifiers and 2 units of service.

The RB modifier which is for the replacement of a part of a DME, orthotic, or prosthetic item furnished as a part of a repair must be appended to the HCPCS code for the replacement footwear.

Shoes which are incorporated into a brace must be billed by the same supplier billing for the brace. Shoes which are billed separately (that are not a part of a brace) will be denied as noncovered. A KX modifier must not be used in this situation.

Therapeutic Shoes Modifiers Billing Reminder (O&P)

The RT (right) and/or LT (left) modifier(s) must be used when billing shoes, inserts, or modifications. If bilateral items are provided on the same date of service, claims should be billed for both items on the same claim line using the RTLT modifiers and 2 units of service. Claims billed without modifiers RT and/or LT will be rejected as incorrect coding.

Suppliers must also add a KX modifier to codes for shoes, inserts, and modifications only if criteria 1-5 in the "Non-Medical Necessity Coverage and Payment Rules" section of the Therapeutic Shoes for Persons with Diabetes LCD Policy Article have been met. This documentation must be available upon request. The Statement of Certifying Physician form is not sufficient to meet this requirement.

Example: *If criteria 1-5 of the policy have been met and the supplier is providing 2 units of A5500 (For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi- density insert(s), per shoe)*

Correct billing: A5500RTLTKX 2 units of service

Refer to the Therapeutic Shoes for Persons with Diabetes LCD for additional information.

Clarifications on the Telephone Reopening Process (GEN)

NHIC, Corp. DME MAC A is experiencing an increase in calls on the telephone reopening line from providers requesting that complex claim research be performed. The Telephone Reopening Unit (TRU) is intended to handle requests for claim corrections due to minor clerical errors and omissions. The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 34, Section 10.5 (**http://www.cms.gov/manuals/downloads/clm104c34.pdf**) states in part, "*CMS believes that most telephone reopenings will consist of clerical errors or omissions that can be corrected quickly and easily over the telephone.*" Section 10.5.2 also states, "*There may be instances where an issue cannot be resolved during the telephone reopening. An issue may not be resolvable on the telephone because: (1) the issue becomes too complex to be handled over the telephone and/or it is in the best interest of the party to have a more in-depth review performed; or (2) there is a need for additional medical documentation from the provider, physician, or other supplier.*" Inquiries regarding why a claim processed the way it did or to troubleshoot claim denials, please be advised that Customer Service is available for these types of inquiries.

The TRU is also experiencing an increase in calls regarding unprocessable claims. These claims can be identified on the Medicare Remittance Advice by the following claim adjustment reason codes: CO-4 or CO-16 and/or the remittance advice remark code MA-130. An example of an unprocessable claim would be "*CO-4; The procedure code is inconsistent with the modifier used, or a required modifier is missing.*" These claims must be resubmitted with the required corrections to be considered for processing. The TRU cannot adjust unprocessable claims.

Questions regarding unprocessable claims should be directed to Customer Service.

When calling the TRU, please be prepared to tell the reopening representative what corrections need to be made to your claim(s). The reopening representatives are unable to troubleshoot claim denials. If asked to troubleshoot or research denials, the telephone reopening representatives will refer providers/suppliers to contact Customer Service.

Customer Service contact information is available on the DME MAC A Web site at:
http://www.medicarenhic.com/dme/contacts.shtml

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Provided During an Inpatient Stay - ANSI Denial Code CO-97 (Change Request 7189) (GEN)

The purpose of this article is to remind suppliers that Part B DMEPOS items with service dates that overlap an inpatient hospital stay will be denied. Medicare payment is available for rental or purchase of durable medical equipment prosthetics orthotics and supplies (DMEPOS) used in a beneficiary's home. A beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or other type of institution. However, an institution may not be considered a beneficiary's home if it is a hospital or a skilled nursing facility (SNF). If an individual is a patient in an institution or a distinct part of an institution that meets the definition of a hospital or SNF, the individual is not entitled to have separate Part B payment made for rental or purchase of DME. **This concept applies even if the patient resides in a bed or portion of the institution not certified for Medicare.**

Previously, if a claim was submitted for a beneficiary and the Common Working File (CWF) identified an overlapping inpatient hospital stay, suppliers would receive ANSI denial code OA-109. However, effective for claims processed on or after April 04, 2011, suppliers could now receive either ANSI denial code OA-109 or ANSI denial code CO-97. The CO-97 denial code would be received with a remark code of M2, which states the following:

- **CO-97** - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- **Remark Code M2** - Not paid separately when the patient is an inpatient.

This recent change will allow the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the opportunity to deny the DMEPOS claims before they are finalized, as appropriate, to avoid future overpayments. In order to prevent this denial from occurring, suppliers should verify during the intake process **and** prior to delivery that the beneficiary is not in an inpatient stay.

In addition, suppliers are also reminded that in most situations the date of service submitted on the claim must match the date the DMEPOS item is delivered to the Medicare beneficiary. Medicare does make one exception to this rule. The exception is when items are provided in anticipation of discharge from a hospital or nursing facility.

A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and shall use the place of service (POS) code 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

A supplier may also deliver a DMEPOS item to a patient's home in anticipation of a discharge from a hospital or nursing facility. The supplier may arrange for actual delivery of the item approximately two days prior to the patient's anticipated discharge to their home. The supplier shall bill the date of service on the claim as the date of discharge and should use the POS code 12 (patient's home). For additional information, please refer to the *Program Integrity Manual*, chapter 4, section 4.26.2 on the Centers for Medicare & Medicaid Services (CMS) Web site at: **http://www.cms.gov/manuals/downloads/pim83c04.pdf**

The CMS requires suppliers to utilize self-service options, such as the interactive voice response (IVR) system. If a claim submitted to the Jurisdiction A DME MAC was denied due to an inpatient stay suppliers are able to obtain the admission/discharge dates and the beneficiary status via the IVR system. The name and the address of the facility are also available. In order to obtain eligibility through the IVR, suppliers can call **866-419-9458** and select option 2.

Please be advised the Jurisdiction A DME MAC Provider Contact Center may experience larger than normal call volume due to Change Request 7189. The contact center peak times are from 11:00 a.m. to 1:00 p.m. If possible, we encourage suppliers to contact us outside of this timeframe to ensure a quicker response. A customer service representative can be reached by calling 866-590-6731.

April 2011 National Supplier Clearinghouse (NSC) Newsletter Now Available (GEN)

The NSC recently announced the availability of the April 2011 NSC Newsletter. This edition features information on enrollment fees as required by CMS-6028-FC. Additional information regarding Internet-based PECOS, supplier revalidations (formerly re-enrollment), appeals and other pertinent enrollment procedures are also available in this edition. To access the details, click on the following link: **http://www.palmettogba.com/palmetto/providers.nsf/ls/National%20Supplier%20Clearinghouse~8FTS7X3773?opendocument**

Updating Supplier Records (GEN)

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

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

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

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

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

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**

Quarterly Provider Update (GEN)

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

Supplier Manual News (GEN)

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

Updates/Corrections Made:
In March of 2011 chapters 1, 2, 3, 4, 5, 6, 8, 10 and 11 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.

Check out the newly revised Electronic Data Interchange section of the DME MAC A Web site at:
http://www.medicarenhic.com/dme/dme_edi.shtml

For Your Notes

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.

We are pleased to announce that 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

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

Written Inquiries

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

Written Inquiry FAX: 781-741-3118

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

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

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Redetermination Requests Fax: 781-741-3118

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

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

Faxed Reopenings: 781-741-3914

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:

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

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Mailing Address:

Same as Draft LCDs Comments

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

Mailing Address:

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

ADMC Requests Fax:

Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

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

DME MAC Jurisdiction A Resource

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

June 2011
Number 20

Publication Information

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

Visit the following websites for more information:

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

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

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

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

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A CMS Contractor

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