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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March 2011
Number 19

Billing Information

General Information

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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

Additional Healthcare Common Procedure Coding System (HCPCS) Codes Payable Under the Replacement Part, Accessories, and Supplies Pricing Logic Established By Change Requests (CRs) 5917 and 6573 (MM7261) (MOB)

MLN Matters® Number: MM7261
Related CR Release Date: January 28, 2011
Related CR Transmittal #: R846OTN

Related Change Request (CR) #:7261
Effective Date: January 1, 2011
Implementation Date: July 5, 2011

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

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued CR7261 in order to provide three additional HCPCS codes for replacement parts, accessories, and supplies for implanted prosthetic devices, which become effective January 1, 2011. These three HCPCS codes are separately billable to the A/B MACs and carriers under the guidelines established by CR5917 and CR6573. The Key Points section of this article lists the three additional HCPCS codes. Make certain billing staffs are aware of this change.

Key Points of CR7261
Beginning January 1, 2011, suppliers that are enrolled with the National Supplier Clearinghouse (NSC) as a DMEPOS supplier may bill Medicare Carriers or A/B MACs for:

- HCPCS codes L8693 (Auditory Osseointegrated Device Abutment, Any Length, Replacement Only);
- Q0478 (Power Adapter for use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type); and
- Q0479 (Power Module for use with Electric/Pneumatic Ventricular Assist Device, Replacement Only).

Medicare contractors will process claims containing such codes, according to the instructions in CR5917 and CR6573.

These Medicare contractors will reprocess any claims containing the three HCPCS codes listed directly above submitted by DMEPOS suppliers with dates of service on or after January 1, 2011, through the implementation date of this CR, according to the guidelines established in CR5917 and CR6573.

When claims containing these codes are submitted to the DME MACs, they will be denied.

Additional Information
The official instruction, CR7261, issued to your Medicare A/B MAC and carrier regarding this change may be viewed at **http://www.cms.gov/transmittals/downloads/R846OTN.pdf** on the CMS website. CMS published *MLN Matters*® article MM6573, related to CR6573, which may be reviewed at **http://www.cms.gov/mlnmattersarticles/downloads/MM6573.pdf** on the CMS website. CMS published *MLN Matters*® article MM5917, related to CR5917, which may be reviewed at **http://www.cms.gov/MLNMattersArticles/downloads/MM5917.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.

April 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7298) (DRU)

MLN Matters® Number: MM7298
Related CR Release Date: January 21, 2011
Related CR Transmittal #: R2135CP

Related Change Request (CR) #: 7298
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7298 which instructs your Medicare contractors to download and implement the April 2011 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised January 2011, October 2010, July 2010, and April 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 April 4, 2011, with dates of service April 1, 2011, through June 30, 2011. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Section 1847A of The *Medicare Modernization Act of 2003* (Section 303(c); see **http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf** on the CMS website) revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis.

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

Files	Effective for Dates of Service
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
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010

Additional Information
The official instruction, CR7298, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/transmittals/downloads/R2135CP.pdf** on the CMS website. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Auto Denial of Claims Submitted With a GZ Modifier (MM7228) (GEN)

MLN Matters® Number: MM7228
Related CR Release Date: February 4, 2011
Related CR Transmittal #: R366PI and R2148CP

Related Change Request (CR) #: 7228
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

What You Need to Know
The Health and Human Services Office of General Counsel (OGC) has provided guidance that Medicare contractors that process both institutional and professional claims have discretion to automatically deny claims billed with the GZ modifier. The GZ modifier indicates that an Advance Beneficiary Notice (ABN) was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy. Medicare Contractors will automatically deny claim line(s) items submitted with a GZ modifier, effective for dates of service on or after July 1, 2011. Further, your Medicare contractor will not perform complex medical review on any claim line item(s) submitted with the GZ modifier. In addition, line items denied due to the presence of the GZ modifier will reflect a Claim Adjustment Reason Code of 50 (These services are non-covered services because this is not deemed a "medical necessity" by the payer.) and a Group Code of CO (Contractual Obligation) to show provider/supplier liability.

Additional Information
The official instruction, Change Request (CR) 7228, was issued to your carrier, FI, A/B MAC, and DME/MAC via two transmittals. The first transmittal modifies the *Medicare Claims Processing Manual* and it is at **http://www.cms.gov/Transmittals/downloads/R2148CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. The second transmittal modifies the *Medicare Program Integrity Manual* and it is at **http://www.cms.gov/Transmittals/downloads/R366PI.pdf** on the same site. If you have any questions, please contact your carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Calendar Year (CY) 2011 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (MM7248) (GEN)

MLN Matters® Number: MM7248 Revised
Related CR Release Date: January 24, 2011
Related CR Transmittal #: R2142CP

Related Change Request (CR) #:7248
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: *This article was revised on January 25, 2011, to make the following changes (in bold): On page 4, codes L3660, L3670 and L3675 were removed from the list of codes deleted from the HCPCS file; On page 5, the purchase fee schedule calculation for complex rehabilitation power wheelchairs was added to the Power-Driven Wheelchairs section; and On page 6, the language was clarified under the CY 2011 Fee Schedule Update Factor section. The transmittal number, CR date and link for viewing the CR was also changed. All other information remains the same.*

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

Provider Action Needed
This article, based on Change Request (CR) 7248, advises you of the CY 2011 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. The annual update process for the DMEPOS fee schedule is documented in the *Medicare Claims Processing Manual*, Chapter 23, Section 60 at **http://www.cms.gov/manuals/downloads/clm104c23.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2011. Be sure your billing staffs are aware of these changes.

Background and Key Points of CR7248
The DMEPOS fee schedule file is available for State Medicaid Agencies, managed care organizations, and other interested parties at **http://www.cms.gov/DMEPOSFeeSched/** on the CMS website.

2011 Update to Labor Payment Rates

2011 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 1.1 percent effective for dates of service on or after January 1, 2011 through December 31, 2011, and those rates are as follows:

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
AK	25.55	29.11	34.25		NC	13.56	20.21	27.44
AL	13.56	20.21	27.44		ND	16.90	29.05	34.25
AR	13.56	20.21	27.44		NE	13.56	20.19	38.26
AZ	16.77	20.19	33.76		NH	14.56	20.19	27.44
CA	20.81	33.19	38.68		NJ	18.30	20.19	27.44
CO	13.56	20.21	27.44		NM	13.56	20.21	27.44
CT	22.65	20.67	27.44		NV	21.61	20.19	37.40
DC	13.56	20.19	27.44		NY	24.98	20.21	27.44
DE	24.98	20.19	27.44		OH	13.56	20.19	27.44
FL	13.56	20.21	27.44		OK	13.56	20.21	27.44
GA	13.56	20.21	27.44		OR	13.56	20.19	39.46
HI	16.77	29.11	34.25		PA	14.56	20.79	27.44
IA	13.56	20.19	32.85		PR	13.56	20.21	27.44
ID	13.56	20.19	27.44		RI	16.17	20.81	27.44
IL	13.56	20.19	27.44		SC	13.56	20.21	27.44
IN	13.56	20.19	27.44		SD	15.15	20.19	36.68
KS	13.56	20.19	34.25		TN	13.56	20.21	27.44
KY	13.56	25.88	35.09		TX	13.56	20.21	27.44
LA	13.56	20.21	27.44		UT	13.60	20.19	42.73
MA	22.65	20.19	27.44		VA	13.56	20.19	27.44
MD	13.56	20.19	27.44		VI	13.56	20.21	27.44
ME	22.65	20.19	27.44		VT	14.56	20.19	27.44
MI	13.56	20.19	27.44		WA	21.61	29.62	35.18
MN	13.56	20.19	27.44		WI	13.56	20.19	27.44
MO	13.56	20.19	27.44		WV	13.56	20.19	27.44
MS	13.56	20.21	27.44		WY	18.91	26.94	38.26
MT	13.56	20.19	34.25					

HCPCS Code Updates

The following new codes are effective as of January 1, 2011:

- A4566, A9273, and EO446 all of which have no assigned payment category;
- A7020,E2622, E2623, E2624, and E2625 in the inexpensive/routinely purchased (DME) payment category:
- E1831 in the capped rental payment category (DME);
- L3674, L4631, L5961, L8693, Q0478, and Q0479, in the prosthetics/orthotics payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2011 DMEPOS Fee Schedule Update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes, where applicable, from January 1, 2011 through June 30, 2011. **The new codes are not to be used for billing purposes until they are effective on January 1, 2011.**

The following codes are being deleted from the HCPCS effective January 1, 2011, and are therefore being removed from the DMEPOS fee schedule files:

- E0220, E0230, and E0238
- K0734, K0735, K0736, and K0737
- L3672 and L3673.

For gap-filling purposes, the 2010 deflation factors by payment category are listed as follows:

Factor	Category
0.502	Oxygen
0.506	Capped Rental
0.507	Prosthetics and Orthotics
0.643	Surgical Dressings
0.700	Parenteral and Enteral Nutrition

Specific Coding and Pricing Issues

Therapeutic shoes and insert fee schedule amounts were implemented as part of the January 2005 Fee Schedule Update as described in Change Request 3574 (Transmittal 369) which may be reviewed at **http://www.cms.gov/transmittals/Downloads/R369CP.pdf** on the CMS website. The payment amounts for shoe modification codes A5503 through A5507 were established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). The fees for codes A5512 and A5513 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004.

As part of this update, CMS is revising the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code as follows:

- Fees for A5512 and A5513 will be weighted based on the approximate total allowed services for each code for items furnished during the Calendar Year 2009;
- The fee schedules for codes A5503 through A5507 are being revised effective January 1, 2011, to reflect this change.

Power-Driven Wheelchairs

In accordance with Section 3136(a)(1) of The *Affordable Care Act of 2010*, effective for claims with dates of service on or after January 1, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule for power-driven wheelchairs furnished on or after January 1, 2011, 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. **The purchase fee schedule amount for complex rehabilitation power wheelchairs is equal to the rental fee (for months 1-3) divided by 0.15.** The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR 7248. This attachment identifies those codes where payment, when applicable, should be made at 15 percent of the purchase price for months 1 through 3 and 6 percent of the purchase price for months 4 through13.

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 1, 2011. For these items, payment for rental claims with dates of service on or after January 1, 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.

Also, Section 3136(c)(2) of The *Affordable Care Act* specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the Medicare DMEPOS Competitive Bidding Program. *MLN Matters*® article MM7181 at **http://www.cms.gov/MLNMattersArticles/downloads/MM7181.pdf** discusses these changes.

For power-driven wheelchairs furnished on a rental basis with dates of service prior to January 1, 2006, for which the beneficiary did not elect the purchase option in month 10 and continues to use, contractors shall continue to pay the maintenance and servicing payment amount at 10% of the purchase price. In these instances, suppliers should continue to use the following HCPCS codes, with the MS modifier, for billing maintenance and servicing, as appropriate:

- K0010 Standard- Weight Frame Motorized/Power Wheelchair
- K0011 Standard- Weight Frame Motorized/Power Wheelchair with Programmable Control Parameters for Speed Adjustment, Tremor Dampening, Acceleration Control and Braking
- K0012 Lightweight Portable Motorized/Power Wheelchair
- K0014 Other Motorized/Power Wheelchair Base

The rental fee schedule payment amounts for codes K0010, K0011 and K0012 will continue to reflect 10 percent of the wheelchair's purchase price.

CY 2011 Fee Schedule Update Factor

The DMEPOS fee schedule amounts are to be updated for 2011 by the percentage increase in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. Also beginning with CY 2011, Section 3401 of The *Affordable Care Act* requires that the increase in the CPI-U be adjusted by changes in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The amendment specifies the application of the MFP may result in an update "being less than 0.0 for a year, and may result in payment rates being less than such payment rates for the preceding year". For CY 2011, the MFP adjustment is 1.2 percent and the CPI-U percentage increase is 1.1 percent. **Therefore, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent increase in the MFP, resulting in a net reduction of 0.1 percent for the MFP-adjusted update factor. In other words, the MFP-adjusted update factor of -0.1 percent is applied to the applicable CY 2010 DMEPOS fee schedule amounts.**

2011 National Monthly Payment Amounts for Stationary Oxygen Equipment

CMS will also implement the 2011 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2011. The fee schedule file is being revised to include the new national 2011 monthly payment rate of $173.31 for stationary oxygen equipment. The payment rates are being adjusted on an annual basis, as necessary, to ensure budget neutrality of the addition of the new Oxygen Generating Portable Equipment (OGPE) class. The revised 2011 monthly payment rate of $173.31 includes the -0.1 percent MFP-adjusted update factor. The budget neutrality adjustment and the MFP-adjusted covered item update factor for 2011 caused the 2010 rate to change from $173.17 to $173.31.

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

2011 Maintenance and Service Payment Amount for Certain Oxygen Equipment

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

The 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator which resulted in a payment of $66 for CY 2010. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the *Social Security Act*. The 2010 maintenance and servicing fee is adjusted by the -0.1 percent MFP-adjusted covered item update factor to yield a CY 2011 maintenance and servicing fee of $65.93 for oxygen concentrators and transfilling equipment.

Specific Billing Issues

Effective January 1, 2011, the payment category for code E0575 (Nebulizer, Ultrasonic, Large Volume) is being revised to move the nebulizer from the DME payment category for frequent and substantial servicing to the DME payment category for capped rental items. The first claim received for each beneficiary for this code with a date of service on or after January 1, 2011 will be counted as the first rental month in the cap rental period.

Code A7020 (Interface for Cough Stimulating Device, Includes All Components, Replacement Only) is added to the HCPCS file effective January 1, 2011. Items coded under this code are accessories used with the capped rental Durable Medical Equipment cough stimulating device coded at E0482. Section 110.3, Chapter 15 of the *Medicare Benefit Policy Manual* at **http://www.cms.gov/Manuals/downloads/bp102c15.pdf** provides that reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary Durable Medical Equipment only if the beneficiary owns or is purchasing the equipment. Therefore, separate payment will not be made for the replacement of accessories described by code A7020 until after the 13-month rental cap has been reached for capped rental code E0482.

The following new codes are being added to the HCPCS file, effective January 1, 2011, to describe replacement accessories for Ventricular Assist Devices (VADs):

- Q0478 (Power Adaptor for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type); and
- Q0479 (Power Module for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only).

Similar to the other VAD supplies and accessories coded at Q0480 thru Q0496, Q0497 thru Q0502, Q0504 and Q0505, CMS has determined the reasonable useful lifetime for codes Q0478 and Q0479 to be one year. CMS is establishing edits to deny claims before the lifetime of these items has expired. Suppliers and providers will need to add HCPCS modifier RA to claims for codes Q0478 and Q0479 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Additionally, code Q0489 (Power Pack Base for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only) should not be used to bill separately for a VAD replacement power module or a battery charger in instances where the power module and battery charger are not integral and are furnished as separate components.

Additional Information
The official instruction, CR7248, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2142CP.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.

Changes to the Time Limits for Filing Medicare Fee-For-Service Claims (MM7270) (GEN)

MLN Matters® Number: MM7270
Related CR Release Date: January 21, 2011
Related CR Transmittal #: R2140CP

Related Change Request (CR) #: 7270
Effective Date: January 1, 2010
Implementation Date: February 22, 2011

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

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 7270, regarding changes to the time limits for filing Medicare Fee-For-Service (FFS) claims.

What You Need to Know
Section 6404 of the *Affordable Care Act* reduced the maximum period for submission of all Medicare Fee-For-Service claims to no more than 12 months, or one calendar year, after the date of service. As a result of the passage of this legislation, the Centers for Medicare & Medicaid Services (CMS) is updating the *Medicare Claims Processing Manual* (Chapter 1) pertaining to the time limits for filing Medicare claims.

What You Need to Do
CR 7270 also establishes exceptions, if certain conditions are met, to the time limit for filing Medicare claims. (See the Background and Additional Information Sections of this article, for further details regarding these changes.)

Background
The *Social Security Act* (Sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B)) as well as the Medicare regulations at 42 CFR §424.44 (see **http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr424.44.pdf** on the Internet), specify the time limits for filing Medicare Fee-For-Service (Part A and Part B) claims.

Prior to the passage of the *Affordable Care Act* on **March 23, 2010, a provider or supplier had from 15 to 27 months** (depending on the date of service) to file a timely claim.

- For services furnished **in the first 9 months of a calendar year**, claims had to be submitted to the appropriate Medicare contractor by **December 31 of the following year.**

- For services furnished **in the last 3 months of a calendar year**, claims had to be submitted to the appropriate Medicare contractor by **December 31 of the second following year.**

The *Affordable Care Act* (Section 6404) reduced the maximum period for submission of all Medicare Fee-For-Service claims to no more than 12 months (one calendar year) after the date services were furnished. This time limit policy for claims submission became effective for services furnished on or after January 1, 2010. In addition, claims for services furnished prior to January 1, 2010, had to be submitted no later than December 31, 2010. The *Affordable Care Act* (Section 6404) also mandated that CMS may specify exceptions to the one calendar year time limit for filing Medicare claims.

CR 7270 instructs that claims for services furnished:

- Prior to January 1, 2010, must be submitted no later than December 31, 2010.
- On or after January 1, 2010, the time limit for filing all Medicare Fee-For-Service claims (Part A and Part B claims) is 12 months, or one calendar year from the date services were furnished.

Exceptions Allowing Extension of Time Limit

Medicare will allow for the following exceptions to the one calendar year time limit for filing Fee-For-Service claims:

- **Administrative Error:** This is where the failure to meet the filing deadline was caused by error or misrepresentation of an employee, the Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notice that an error or misrepresentation was corrected.

- **Retroactive Medicare Entitlement:** This is where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the beneficiary, provider, or supplier received notification of Medicare entitlement retroactive to or before the date of the furnished service.

- **Retroactive Medicare Entitlement Involving State Medicaid Agencies:** This is where a State Medicaid Agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactive to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which a State Medicaid Agency recovered Medicaid payment from a provider or supplier.

- **Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization:** This is where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups its payment from a provider or supplier six months or more after the date the service was furnished. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider or supplier.

Additional Information

The official instruction, CR 7270, issued to your Carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/transmittals/downloads/R2140CP.pdf** on the CMS website. Attached to CR 7270 are the revised Manual instructions, which provide complete details on the timely filing requirements, including the exceptions process. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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

MLN Matters® Number: MM6625 Revised
Related CR Release Date: December 3, 2010
Related CR Transmittal #: R2112CP
Related Change Request (CR) #: 6625
Effective Date: April 1, 2011
Implementation Date: July 5, 2011

Note: *This article was revised on December 6, 2010, to reflect a revision to CR 6625. The implementation date has been changed to July 5, 2011. The CR release date, transmittal number, and the Web address for accessing CR 6625 has been revised. All other information is the same.*

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

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

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

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

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

Additional Information
You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R2112CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your FI, RHHI, carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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

MLN Matters® Number: MM7300
Related CR Release Date: December 29, 2010
Related CR Transmittal #: R828OTN

Related Change Request (CR) #:7300
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

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/R828OTN.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:

	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

	JURIS	CATG	L3660	L3670	L3675
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
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/R828OTN.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.

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.

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

MLN Matters® Number: MM7064 Revised
Related CR Release Date: January 14, 2011
Related CR Transmittal #: R2134CP

Related Change Request (CR) #: 7064
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Note: *This article was revised on January 18, 2011. To reflect the revised CR 7064 that was issued on January 14, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7064 were revised. All other information is the same.*

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

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

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

What You Need to Do
Since the ESRD PPS is effective for services on or after January 1, 2011, it is important that providers not submit claims spanning dates of service in 2010 and 2011. ESRD facilities have the opportunity to make a onetime election to be excluded from the transition period and have their payment based entirely on the payment amount under the ESRD PPS as of January 1, 2011. Facilities wishing to exercise this option must do so on or before November 1, 2010. See the Background and Additional Information Sections of this article for further details regarding the ESRD PPS.

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

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

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

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

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

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

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

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

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

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

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

Treatments furnished to pediatric patients:

- Can qualify for a training add-on payment (when applicable), and
- Are eligible for an outlier adjustment.

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

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

The ESRD PPS 4-year Transition Period Blended Rate Determination

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

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

The **ESRD PPS base rate is $229.63**, which is applicable for both adult and pediatric ESRD patients effective January 1, 2011. This base rate will be wage adjusted as mentioned above where

- The labor-related share of the base rate from the ESRD PPS market basket is 0.41737, and
- The non labor-related share of the base rate is $133.79 ((229.63 X (1 - 0.41737) = $133.79).

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

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:

- Patient-level adjustments;
- Outlier adjustments;
- Facility-level adjustments; and
- Training add-on payments (adjusted for area wage levels)

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

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

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

Three New Adjustments Applicable to the Adult Rate

1. **Comorbid Adjustments:** The new ESRD PPS provides for **3 categories of chronic comorbid conditions and 3 categories for acute comorbid conditions**. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. **The 3 chronic comorbid** categories eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia;
   - Monoclonal gammopathy (in the absence of multiple myeloma); and
   - Myelodysplastic syndrome.

   The 3 acute comorbid categories eligible for a payment adjustment are:
   - Bacterial Pneumonia;
   - Gastrointestinal Bleeding; and
   - Pericarditis.

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

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

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

Therefore, all home dialysis claims:
- Must be submitted by a renal dialysis facility and
- Will be processed as Method I claims.

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

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

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

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

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

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

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

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

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

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

Additional Information
The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2134CP.pdf** on the CMS website. Attached to CR 7064, you may find the following documents to be helpful:

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

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

Pharmacy Billing for Drugs Provided "Incident to" a Physician's Service (MM7109) (DRU)

MLN Matters® Number: MM7109
Related CR Release Date: December 10, 2010
Related CR Transmittal #: R2115CP
Related Change Request (CR) #: 7109
Effective Date: March 14, 2011
Implementation Date: March 14, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7109 which clarifies the Centers for Medicare & Medicaid Services (CMS) policy with respect to restrictions on pharmacies billing for drugs provided "incident to" a physician's service. CR 7109 also clarifies the CMS policy for the local determination of payment limits for drugs that are not nationally determined.

Background
Pharmacies may bill Medicare for certain classes of drugs including:

- Immunosuppressive drugs,
- Oral anti-emetic drugs,
- Oral anti-cancer drugs, and
- Drugs administered through any piece of Durable Medicare Equipment (DME).

  Claims for these drugs are generally submitted to the DME MAC, and the DME MAC makes payment for these drugs (when deemed to be covered and reasonable and necessary) to the pharmacy. One exception is that claims for drugs administered through implanted durable medical equipment such as an implanted infusion pump are submitted to the A/B MAC or local carrier. All bills submitted to the DME MAC must be submitted on an assigned basis by the pharmacy. (*Medicare Claims Processing Manual* (Chapter 17, Section 50.B; see **http://www.cms.gov/manuals/downloads/clm104c17.pdf** on the CMS website).

Pharmacies, suppliers, and providers may not bill Medicare for drugs purchased directly by beneficiaries for administration "incident to" a physician service. Medicare will deny such claims.(See the *Medicare Claims Processing Manual*, Chapter 17, Section 50.B at **http://www.cms.gov/manuals/downloads/clm104c17.pdf** on the CMS website.) Pharmacies also may not bill for drugs purchased by a physician for administration to a Medicare beneficiary. These drugs are being furnished "incident to" the physician's service and as such must be billed by the physician. (See *Medicare Benefit Policy Manual*, Chapter 15, Section 50.3; at **http://www.cms.gov/manuals/Downloads/bp102c15.pdf** on the CMS website).

The payment limits for drugs and biologicals that are not included in 1) the average sales price (ASP) Medicare Part B Drug Pricing File or 2) the Not Otherwise Classified (NOC) Pricing File are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing except under 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.

Additional Information
The official instruction, CR 7109, issued to your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2115CP.pdf** on the CMS website. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, and/or RHHIs at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Place of Service Indicator for HCPCS Codes G0339 and G0340 (JSM11066) (GEN)

The Pricing Indicator Code on the Alpha-Numeric HCPCS File has been changed from "00" to "13" for HCPCS codes G0339 and G0340. This change is effective for services furnished in CY 2006 – CY 2010.

Clarification of Existing Policy Regarding Items and Services Included Under the End Stage Renal Disease (ESRD) Composite Payment Rate (CR7312) (SPE)

CMS Manual System
Pub 100-02 Medicare Benefit Policy
Transmittal 136

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Date: JANUARY 28, 2011
Change Request 7312

SUBJECT: Clarification of Existing Policy Regarding Items and Services Included Under the End Stage Renal Disease (ESRD) Composite Payment Rate

I. SUMMARY OF CHANGES: This change request provides clarification to the existing policy regarding items and services included under the End Stage Renal Disease composite rate located in Pub. 100-02, *Medicare Benefit Policy Manual*, chapter 11, section 30.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: February 25, 2011

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/30/Composite Rate for Outpatient Maintenance Dialysis

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction
Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal: 136	Date: January 28, 2011	Change Request: 7312

SUBJECT: Clarification of Existing Policy Regarding Items and Services Included Under the End Stage Renal Disease (ESRD) Composite Payment Rate

Effective Date: January 1, 2011
Implementation Date: February 25, 2011

I. GENERAL INFORMATION

A. Background: CMS has received numerous inquiries about whether or not certain types of protective catheter coverings are considered to be an ESRD-related service and, as such, included under the ESRD composite rate. In response to these questions, this change request provides clarification to the existing policy regarding items and services included under the ESRD composite rate for dialysis patients, located in Pub 100-02, *Medicare Benefit Policy Manual*, chapter 11, section 30. As dressings or protective catheter coverings may be used to protect the dialysis access site, these supplies are considered ESRD-related and are included in the ESRD composite rate for all dialysis patients regardless of the method of dialysis, or where they receive dialysis treatment, and, therefore are not separately billable. All dressings and protective catheter coverings are also included in the ESRD Prospective Payment System (PPS) bundled payment amount, effective January 1, 2011.

B. Policy: ESRD facilities and Monthly Capitated Payment (MCP) physicians and practitioners may determine that it is medically required for a dialysis patient to use dressings or protective access coverings, including catheter coverings, on their access site. All medically required dressings or protective access coverings used during or after dialysis to protect a dialysis patient's access site, including for example, coverings used for day-to-day activities such as bathing, are considered to be ESRD-related items. To the extent that dressings and protective access coverings, including catheter coverings, are determined to be medically required, an ESRD facility can provide them. Medicare payment for ESRD-related items and services are included in the ESRD composite payment rate, and are therefore included in the ESRD PPS, for all dialysis patients regardless of the method of dialysis or where they receive dialysis treatments.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility(place an "X" in each applicable column)									
		A/BMAC	DMEMAC	FI	CARRIERS	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7312.1	Medicare contractors shall ensure that their policies acknowledge that all dressings and/or protective access coverings are included in the ESRD composite rate and ESRD PPS bundled base rate and therefore are not separately payable.	X	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility(place an "X" in each applicable column)									
		A/BMAC	DMEMAC	FI	CARRIERS	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7312.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with the listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): DME suppliers: **Susan.Webster@cms.hhs.gov** or (410) 786-3384. ESRD facility claim inquires: **Wendy.Tucker@cms.hhs.gov** or (410) 786-3004. ESRD payment policy: **Michelle.Cruse@cms.hhs.gov** or (410) 786-7540.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

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

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

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

30 - Composite Rate for Outpatient Maintenance Dialysis

(Rev. 136, Issued: 01-28-11, Effective: 01-01-11, Implementation: 02-25-11)

The composite payment rate system is a prospective system for the payment of outpatient maintenance dialysis services furnished to Medicare beneficiaries. All maintenance dialysis treatments furnished to Medicare beneficiaries in an approved ESRD facility are covered by this system. Further, the composite rate system is one of two methods by which Medicare pays for maintenance dialysis performed in a beneficiary's home. (For a description of the other method, see §50)

The facility's composite payment rate is a comprehensive payment for all modes of infacility and Method I home dialysis. Most items and services related to the treatment of the patient's end-stage renal disease are covered under the composite rate payment. The cost of an item or service is included under the composite rate unless specifically excluded. Therefore, the determination as to whether an item or service is covered under the composite rate payment does not depend on the frequency that dialysis patients require the item or service or the number of patients who require it. The composite rate is payment for the complete dialysis treatment except for physicians' professional services, separately billable laboratory services, and separately billable drugs. This payment is subject to the normal Part B deductible and coinsurance requirements.

Under the composite rate, a dialysis facility must furnish all of the necessary dialysis services, equipment, and supplies. If it fails to furnish (either directly under arrangement or under an agreement with another approved ESRD facility) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish.

A certified hospital-based outpatient dialysis facility that is not the patient's usual facility can provide and must bill Medicare directly for routine maintenance services. The certified hospital-based dialysis facility cannot bill the patient's usual facility for payment and have the patient's usual facility bill Medicare.

Other ESRD Items and Services

Items and services included under the composite rate must be furnished by the facility, either directly or under arrangements to all of its dialysis patients. Examples of such items and services are:

- Bicarbonate dialysate;
- Cardiac monitoring;
- Catheter changes (Ideal Loop);
- Suture removal;
- Dressing changes *(all dressings or protective access coverings, including catheter coverings, used to conceal a dialysis patient's access site, for any purpose, including allowing dialysis patients to bathe or shower as well as perform other day-to-day activities, are included in the composite rate)*;
- Crash cart usage for cardiac arrest;
- Declotting of shunt performed by facility staff in the dialysis unit;
- All oxygen and its administration furnished in the dialysis unit;
- Staff time to administer blood;
- Staff time used to administer separately billable parenteral items; and

- Staff time used to collect specimens for all laboratory tests.

Sometimes outpatient dialysis related services (e.g., declotting of shunts, suture removal, injecting separately billable ESRD related drugs) are furnished in a department of the hospital other than the dialysis unit (e.g., the emergency room (ER)). These services may be paid in addition to the composite payment rate only if the services could not be furnished in a dialysis facility or the dialysis unit of the hospital, due to the absence of specialized equipment or staff found only in the other department. In the case of emergency services furnished in the hospital ER, the services are paid separately subject to the additional requirement that there is a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention in the ER could reasonably be expected to result in either:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Since the above noted situations rarely occur, they require clinical documentation to validate they were met; otherwise, they would be denied services.

1099-MISC Form Information (GEN)

NHIC, Corp. mailed all 1099 Forms for calendar year (CY) 2010 on January 28, 2011. Suppliers can expect 1099 Forms to arrive within 7-10 business days from the date of mailing.

Medicare suppliers and beneficiaries who are serviced by NHIC, Corp. will receive a single Part A, Part B, and Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC) combined by TIN from NHIC for CY 2010.

In accordance with the Internal Revenue Code, contractors are required to issue 1099-MISC forms to all suppliers that received payments greater than $600 within the calendar year. Any questions pertaining to the receipt or amount recorded on your 1099-MISC should be directed to:

NHIC, Corp
Attn: DME Written Inquiries
PO Box 9146
Hingham, MA 02043-9146

Common Question/Concerns:

What should I do if I did not receive a 1099?

Verify that you have received greater than $600 in payments and that your mailing address is current at the National Supplier Clearinghouse (NSC). If the answer is yes to both of these questions, contact the NHIC, Corp. Customer Service Department at 1-866-590-6731.

What address will my 1099 be mailed to?

1099's are mailed to the address on record with the NSC.

My mailing address is not current at the National Supplier Clearinghouse.

A new 855 form will need to be submitted to the NSC. Once the address is updated, contact the NHIC, Corp. Customer Service Department at 1-866-590-6731 and request that a duplicate 1099 be issued.

My 1099 has been misplaced, how can I obtain a duplicate?

Send a written request to the NHIC, Corp. Written Inquiries Department address above or contact the NHIC, Corp. Customer Service Department at 1-866-590-6731.

How was the figure reported in Box 6 (Medical and health care payments) calculated?

The 1099 amount is calculated by totaling the amount of money paid to the supplier during the reporting year (this includes claim payments that were offset on established account receivables).

I have verified my records and do not agree with the amount reported on the 1099.

Send a letter to the NHIC, Corp. Written Inquiries Department detailing your concern.

A 1099-Misc was received but I am tax-exempt.

NHIC, Corp is required to issue 1099-MISC form in accordance with the Internal Revenue Code. It is the responsibility of the supplier to contact the IRS pertaining to tax status and reporting requirements.

The Tax Identification Number is incorrect on my 1099-MISC.

The Tax Identification Number recorded on the 1099 is the number that is on record at the NSC. A new 855 form will need to be submitted to the NSC to correct your TIN.

2011 Fees for Repairs (CR7248) (GEN)

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

The below table identifies the 2011 fee schedule for K0739, L4205, L7520 for claims with dates of service from January 01, 2011, through December 31, 2011.

State	K0739	L4205	L7520
CT	22.65	20.67	27.44
DC	13.56	20.19	27.44
DE	24.98	20.19	27.44
MA	22.65	20.19	27.44
MD	13.56	20.19	27.44
ME	22.65	20.19	27.44
NH	14.56	20.19	27.44
NJ	18.30	20.19	27.44
NY	24.98	20.21	27.44
PA	14.56	20.79	27.44
RI	16.17	20.81	27.44
VT	14.56	20.19	27.44

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:

- 2011 Fees For Repairs
- 1st Quarter 2011 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2011 Average Sales Price Medicare Part B Drug Pricing File
- 1st Quarter 2011 Oral Anticancer Drug Fees

- 4th Quarter 2010 Average Sales Price Medicare Part B Drug Pricing File - Revised

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

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

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

2011 Durable Medical Equipment Prosthetics, Orthotics, and Supply (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List (MM7257) (GEN)

MLN Matters® Number: MM7257
Related CR Release Date: January 14, 2011
Related CR Transmittal #: R2132CP

Related Change Request (CR) #:7257
Effective Date: January 1, 2011
Implementation Date: February 15, 2011

Provider Types Affected
Suppliers submitting claims to Medicare contractors (DME Medicare Administrative Contractors (DME MACs), Part B Carriers, and Medicare Administrative Contractors (A/B MACs)) for DMEPOS services provided to Medicare beneficiaries are affected.

Provider Action Needed
This article is informational and based on Change Request (CR) 7257 that notifies providers that the spreadsheet containing an updated list of the Healthcare Common Procedure Coding System (HCPCS) codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2011 Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at **http://www.cms.gov/center/dme.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information
The official instruction, CR7257, issued to your Medicare A/B MAC, carrier and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2132CP.pdf** on the CMS website. The 2011 Jurisdiction List is also attached to CR7257. 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.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update (MM7250) (GEN)

MLN Matters® Number: MM7250 Revised
Related CR Release Date: January 7, 2011
Related CR Transmittal #: R2131CP

Related Change Request (CR) #: 7250
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Note: *This article was revised on February 11, 2011, to add a reference to MLN Matters® article MM7218, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM7218.pdf**, to alert providers that effective July 1, 2001, the MREP software is being modified to be compatible with Microsoft Windows 7, Vista, and XP operating systems. All other information is unchanged.*

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) 7250, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2011. 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; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November, although the Committee meets every month.

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 lists, as announced in CR7250.

Additional Information
To see the official instruction (CR7250) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC, refer to **http://www.cms.gov/Transmittals/downloads/R2131CP.pdf** on the CMS website. If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010

Modified Codes - CARC

Code	Modified Narrative	Effective Date
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. This change effective 7/1/2011: Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Note: If an adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	10/17/2010
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010
219	Based on extent of injury (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution). This change effective 7/1/2011: Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010

Code	Modified Narrative	Effective Date
W1	Workers Compensation State Fee Schedule Adjustment. This change effective 7/1/2011: Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010

Deactivated Codes - CARC

None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N540	Payment adjusted based on the interrupted stay policy.	Yes
N541	Mismatch between the submitted insurance type code and the information stored in our system.	Yes

Modified Codes - RARC

Code	Modified Narrative	Medicare Initiated
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	No

Deactivated Codes – RARC

None

Claim Status Category and Claim Status Code Update (MM7259) (GEN)

MLN Matters® Number: MM7259
Related CR Release Date: December 17, 2010
Related CR Transmittal #: R2120CP

Related Change Request (CR) #: 7259
Effective Date: April 1, 2011
Implementation Date: April 4, 2011

Provider Types Affected

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

Provider Action Needed

This article, based on Change Request (CR) 7259, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement were updated during the January 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting are to be posted at **http://www.wpc-edi.com/content/view/180/223/** on or about March 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 April 4, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

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

Additional Information
If you have questions, please contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the Centers for Medicare & Medicaid Services (CMS) website. The official instruction, (CR7259), issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2120CP.pdf** on the CMS website.

Claims Modifiers for Use in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (SE1035) (GEN)

MLN Matters Number: SE1035 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 January 10, 2011 to clarify and add language regarding the use of modifier KY. All other information remains unchanged.*

Provider Types Affected
All Medicare Fee-For-Service (FFS) providers and suppliers who provide Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to Medicare beneficiaries with Original Medicare who reside in a Competitive Bidding Area (CBA), including: contract and non-contract suppliers; physicians and other treating practitioners providing walkers to their own patients; hospitals providing walkers to their own patients; and Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) that provide enteral nutrition to residents with a permanent residence in a CBA.

Background
Under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, beneficiaries with Original Medicare who obtain competitive bidding items in designated CBAs are required to obtain these items from a contract supplier, unless an exception applies. The first phase of the program **begins on January 1, 2011**, in nine CBAs for nine product categories.

In order for Medicare to make payment, where appropriate, for claims subject to competitive bidding, it is important that all providers and suppliers who provide DMEPOS affected by the program use the appropriate modifiers on each claim.

Note: *To ensure accurate claims processing, it is critically important for suppliers to submit each claim using the billing number/ National Provider Identifier (NPI) of the location that furnished the item or service being billed.*

Competitive Bidding Modifiers
New Healthcare Common Procedure Coding System (HCPCS) modifiers have been developed to facilitate implementation of various policies that apply to certain competitive bidding items. The new HCPCS modifiers used in conjunction with claims for items subject to competitive bidding are defined as follows:

- J4-DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished by a Hospital Upon Discharge.
- KG- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1.

- KK- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2.
- KU- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3.
- KW-DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4.
- KY-DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5.
- KL-DMEPOS Item Delivered via Mail.
- KV-DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished as Part of a Professional Service.
- KT-Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Area and Receives a Competitive Bid Item.

Suppliers should submit claims for competitive bidding items using the appropriate HCPCS code and corresponding competitive bidding modifier in effect during a contract period. The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The modifiers associated with particular competitive bid codes, such as the KG, KK, or KL modifiers, are listed by competitive bid product category on the single payment amount public use charts found under the supplier page at **http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf** on the Competitive Bidding Implementation Contractor (CBIC) website.

Failure to use or inappropriate use of a competitive bidding modifier on a competitive bidding claim leads to claims denial. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Another modifier was developed to facilitate implementation of DMEPOS fee schedule policies that apply to certain competitive bidding items that were bid prior to July 1, 2008, under the initial Round I of the DMEPOS Competitive Bidding Program. The KE modifier is defined as follows:

- KE-DMEPOS Item Subject to DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment.

How to Use the Modifiers

Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge - The J4 Modifier

Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Please note that separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 in combination with the following HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier, to claims submitted for these items.

The J4 modifier should not be used by contract suppliers.

Modifiers for HCPCS Accessory or Supply Codes Furnished in Multiple Product Categories - The KG, KK, KU, and KW Modifiers

The **KG, KK, KU and KW modifiers** are modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and non-competitively bid items. For example, HCPCS code E0981 *Wheelchair Accessory, Seat Upholstery, Replacement Only, Each* is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a standard power wheelchair shall submit E0981 claims using the KG modifier. Contract suppliers for the complex rehabilitative power

wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a complex power wheelchair shall submit claims for E0981 using the KK modifier. Another example of the use of the KG modifier is with code A4636 *Replacement, Handgrip, Cane, Crutch, or Walker, Each*. Contract suppliers for the walkers and related accessories product category in addition to other suppliers submitting claims for this accessory item when used with a walker shall submit A4636 claims using the KG modifier.

All suppliers that submit claims for beneficiaries that live in a CBA, including contract, non-contract, and grandfathered suppliers, should submit claims for competitive bid items using the above mentioned competitive bidding modifiers. Non-contract suppliers that furnish competitively bid supply or accessory items to traveling beneficiaries who live in a CBA must use the appropriate KG or KK modifier with the supply or accessory HCPCS code when submitting their claim. Also, grandfathered suppliers that furnish competitively bid accessories or supplies used in conjunction with a grandfathered item must include the appropriate KG or KK modifier when submitting claims for accessory or supply codes. The KG and KK modifiers are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use.

The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers (i.e. KG, KK, KL) are denoted in the single payment amount public use charts found under the supplier page at **http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf** on the CBIC website.

Purchased Accessories & Supplies For Use With Grandfathered Equipment - The KY Modifier
Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011, for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:

- 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

Until notified otherwise, grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. The single payment amounts for items included in the Round 1 Rebid of the DMEPOS Competitive Bidding Program can be found under the Single Payment Amount tab on the following website: http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/docsCat/Suppliers on the Internet.. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. Also, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.

After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

Mail Order Diabetic Supplies - The KL Modifier
Contract suppliers must use the KL modifier on all claims for diabetic supply codes that are furnished via mail order. Non contract suppliers that furnish mail order diabetic supplies to beneficiaries who do not live in CBAs must also continue to use the KL modifier with these codes. Suppliers that furnish mail-order diabetic supplies that fail to use the HCPCS modifier KL on the claim may be subject to significant penalties. For claims with dates of service prior to implementation of a national mail order competitive bidding program, the KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence via mail order or are obtained from a local supplier storefront. Once a national mail order competitive bidding program is implemented, the definition for mail order item will change to include all diabetic supply codes delivered to the beneficiary via any means. At this time, the KL modifier will need to be used for all diabetic supply codes except for claims for items that a beneficiary or caregiver picks up in person from a local pharmacy or supplier storefront.

Physicians and Treating Practitioners Who Furnish Walkers and Related Accessories to Their Own Patients but Who Are Not Contract Suppliers - The KV Modifier

The **KV modifier** is to be used by physicians and treating practitioners who are not contract suppliers and who furnish walkers and related accessories to beneficiaries in a CBA. Walkers that are appropriately furnished in accordance with this exception will be paid at the single payment amount.

To be paid for walkers as a non-contract supplier, physicians and treating practitioners should use the modifier KV in combination with the following

HCPCS codes: A4636; A4637; E0130; E0135; E0140; E0141; E0143; E0144; E0147; E0148; E0149; E0154; E0155; E0156; E0157; E0158; and E0159. On the claim billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), the walker line item must have the same date of service as the professional service office visit billed to the Part A/Part B MAC. Physicians and treating practitioners are advised to submit the office visit claim and the walker claim on the same day to ensure timely and accurate claims processing.

Physicians and treating practitioners who are located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries who live in a CBA must affix the KV modifier to claims submitted for these items.

The KV modifier should not be used by contract suppliers.

Traveling Beneficiaries - The KT Modifier

Suppliers must submit claims with the **KT modifier** for non-mail-order DMEPOS competitive bidding items that are furnished to beneficiaries who have traveled outside of the CBA in which they reside. If a beneficiary who lives in a CBA travels to an area that is not a CBA and obtains an item included in the competitive bidding program, the non contract supplier must affix this modifier to the claim. Similarly, if a beneficiary who lives in a CBA travels to a different CBA and obtains an item included in the competitive bidding program from a contract supplier for that CBA, the contract supplier must use the KT modifier.

SNFs and NFs that are not contract suppliers and are not located in a CBA must also use the KT modifier on claims for enteral nutrition items furnished to residents with a permanent home address in a CBA. SNF or NF claims that meet these criteria and are submitted without the KT modifier will be denied.

Claims for mail-order competitive bidding diabetic supplies submitted with the KT modifier will be denied. Contract suppliers must submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary's permanent home address.

To determine if a beneficiary permanently resides in a CBA, a supplier should follow these two simple steps:

1. Ask the beneficiary for the ZIP code of his or her permanent residence. This is the address on file with the Social Security Administration (SSA).

2. Enter the beneficiary's ZIP code into the CBA finder tool on the home page of the Competitive Bidding Implementation Contractor (CBIC) website, found at **http://www.dmecompetitivebid.com** on the Internet.

The KE Modifier

Section 154(a)(2) of the *Medicare Improvements for Patients and Providers Act (MIPPA) of 2008* mandated a fee schedule covered item update of -9.5% for 2009 for items included in the Round I of the DMEPOS Competitive Bidding Program. This covered item update reduction to the fee schedule file applies to items furnished on or after January 1, 2009, in any geographical area. In order to implement the covered item update required by MIPPA, the KE modifier was added to the DMEPOS fee schedule file in 2009 to identify Round I competitively bid accessory codes that could be used with both competitively bid and non-competitively bid base equipment. All suppliers must use the **KE modifier** on all Part B Fee-For-Service claims to identify when a Round I bid accessory item is used with a non-competitively bid base item (an item that was not competitively bid prior to July 2008).

For example, HCPCS code E0950 *Wheelchair Accessory, Tray, Each* can be used with both Round I competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). All suppliers must use the KE modifier with the accessory code to identify when E0950 is used in conjunction with a non-competitively bid manual wheelchair (K0001 thru K0009) or a miscellaneous power wheelchair (K0898). The KE modifier should not be used with competitive bid accessory HCPCS codes that are used with any competitive bid base item that was included in the initial Round I of the Competitive Bidding Program prior to July 1, 2008. Therefore, in the above example, KE is not valid for use with accessory code E0950 when used with standard power wheelchairs,

complex rehabilitative power wheelchairs (Group 2 or Group 3), or any other item selected for competitive bidding prior to July 1, 2008.

For beneficiaries living in competitive bid areas on or after January 1, 2011, suppliers should not use the KE modifier to identify competitively bid accessories used with base equipment that was competitively bid under the Round I Rebid Competitive Bidding Program. Rather, such claims should be submitted using the appropriate KG or KK modifiers as identified on the single payment amount public use charts found under the supplier page at **http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf** on the CBIC website.

Below is a chart that illustrates the relationship between the competitive bid modifiers (KG, KK, KU, and KW) and the KE modifier using competitively bid accessory code E0950:

Accessory Code E0950 used with a:	Base Code Competitive Bid Status	Claim for a Beneficiary who Permanently Lives in a CBA	Claim for a Beneficiary who Permanently Lives Outside a CBA*
Manual Wheelchair (K0001 thru K0009) or Miscellaneous Power Wheelchair (K0898)	Non- Bid	Bill with KE modifier	Bill with KE modifier
Standard Power Wheelchair (K0813 thru K0829)	Bid in Round 1 and the Round 1 Rebid	Bill with KG modifier	Bill without KE modifier
Complex Rehabilitative Group 2 Power Wheelchair (K0835 thru K0843)	Bid in Round 1 and the Round 1 Rebid	Bill with KK modifier	Bill without KE modifier
Complex Rehabilitative Group 3 Power Wheelchair (K0848 thru K0864)	Bid in Round 1	Bill without KE, KK or KG modifier	Bill without KE modifier

* The competitive bid modifiers (KG, KK, KU, and KW) are only used on claims for beneficiaries that live in a Competitive Bidding Area (CBA).

Additional Information

The *Medicare Learning Network*® (MLN) has prepared several fact sheets with information for non-contract suppliers and referral agents, including fact sheets on the hospital and physician exceptions, enteral nutrition, mail order diabetic supplies, and traveling beneficiaries, as well as general fact sheets for non-contract suppliers and referral agents. They are all available, free of charge, at **http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf** on the Internet.

For more information about the DMEPOS Competitive Bidding Program, including a list of the first nine CBAs and items included in the program, visit **http://www.cms.gov/DMEPOSCompetitiveBid** on the Centers for Medicare & Medicaid Services (CMS) dedicated website.

Information for contract suppliers can be found at the CBIC website at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home** on the Internet. Beneficiary-related information can be found at **http://www.medicare.gov** on the Internet.

Elimination of Lump Sum Purchase Payment for Standard Power Wheelchairs Furnished on or after January 1, 2011 due to the Affordable Care Act (MM7116) (MOB)

MLN Matters® Number: MM7116
Related CR Release Date: October 15, 2010
Related CR Transmittal #: R786OTN

Related Change Request (CR) #: 7116
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs) for the lump sum purchase for standard power wheelchairs.

What You Need to Know
This article is based on Change Request (CR) 7116 which informs Medicare DME MACS and RHHIs that Section 3136 of the *Affordable Care Act* eliminates the lump sum purchase payment for standard power wheelchairs, effective for items furnished on or after January 1, 2011. This elimination of the lump sum purchase payment applies to Health Care Common Procedural Coding System (HCPCS) codes K0813 through K0831 and code K0898 submitted with the NU or UE modifier for items furnished on or after January 1, 2011. (**Note:** This change will not apply to standard power wheelchairs furnished to beneficiaries in the nine competitive bidding areas (CBAs) of Round 1 Rebid of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program with dates of service January 1, 2011 thru December 31, 2013.) See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Power wheelchairs are included in the capped rental DME payment category and suppliers have been required to offer beneficiaries the option of receiving power wheelchairs on either a lump sum purchase basis or monthly rental basis. Claims for purchase of DME are submitted with the HCPCS modifier NU (purchase of new equipment) or UE (purchase of used equipment) while claims for rental of durable medical equipment are submitted with the HCPCS modifier RR. Beginning with items initially rented on or after January 1, 2006, suppliers have been required to transfer the equipment title for rented power wheelchairs to the beneficiary after the 13th month of continuous use.

Previous instructions on payment for power wheelchairs were released in Transmittal 918, Change Request (CR) 5010, dated April 28, 2006, and Transmittal 1037, CR 5255, dated August 25, 2006. *MLN Matters*® articles related to these transmittals are available at **http://www.cms.gov/MLNMattersArticles/downloads/MM5010.pdf** and **http://www.cms.gov/MLNMattersArticles/downloads/MM5255.pdf**, respectively.

Effective for items furnished on or after January 1, 2011, section 3136 of the *Affordable Care Act* eliminates the lump sum purchase payment for standard power wheelchairs. Suppliers must furnish these items on a monthly rental basis like other capped rental DME other than power wheelchairs. This elimination of lump sum purchase payment applies to standard power wheelchairs classified under the HCPCS codes for Group 1 power wheelchairs or Group 2 power wheelchairs without additional power options. The current HCPCS codes identifying standard power wheelchairs include codes K0813 thru K0831 and code K0898 for miscellaneous standard power wheelchairs. Claims with dates of service on or after January 1, 2011, for these HCPCS codes with modifier NU or UE will be denied since the statute prohibits payment on a purchase basis for these items. These codes are described in the following table.

HCPCS Code	Description
K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

HCPCS Code	Description
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 126 TO 300 POUNDS
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 126 TO 300 POUNDS
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED

Payment can continue to be made on a lump sum purchase basis or monthly rental basis for complex rehabilitative power wheelchairs. Complex rehabilitative power wheelchairs include Group 2 power wheelchairs with additional power options and Group 3 and higher power wheelchairs (HCPCS codes K0835 through K0843 and K0848 through K0864 as defined in Attachment B of CR 7116, which is available at **http://www.cms.gov/Transmittals/downloads/R786OTN.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

In addition, this change will not apply to standard power wheelchairs furnished to beneficiaries in the nine competitive bidding areas (CBAs) of Round 1 Rebid of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program with dates of service January 1, 2011 thru December 31, 2013. The lump sum purchase payment method remains available for claims with dates of service January 1, 2011 thru December 31, 2013 for standard power wheelchairs furnished to beneficiaries residing in these nine CBAs.

Also, Section 3136 of *Affordable Care Act* changes the monthly fee schedule amounts for rental of standard and complex rehabilitative power wheelchairs furnished on or after January 1, 2011. Instructions for the revised fee schedule amounts are in the CY 2011 annual update for the DMEPOS fee schedule.

Additional Information
The official instruction, CR 7116, issued to your DME MAC or RHHI regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R786OTN.pdf** on the CMS website.
If you have any questions, please contact your 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.

Expansion of Durable Medical Equipment (DME) Supplier Standards (SE1032) (GEN)

MLN Matters® Number: SE1032
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
Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) submitting claims to Medicare DME Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries are impacted by this Special Edition (SE) 1032.

Provider Action Needed
This article alerts suppliers that the Centers for Medicare & Medicaid Services (CMS) expanded the enrollment standards that DMEPOS suppliers must meet in order to establish and/or maintain billing privileges in the Medicare Program. CMS issued these revisions to ensure that only legitimate DMEPOS suppliers participate in the Medicare program and are providing DMEPOS items to Medicare beneficiaries. Be certain your billing staffs are aware of these changes.

Background
On August 27, 2010 CMS published a final rule titled, *Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards* (CMS-6036-F) in the Federal Register. This final rule, effective September 27, 2010, may be reviewed at **http://edocket.access.gpo.gov/2010/pdf/2010-21354.pdf** on the Internet. This final rule clarifies, expands, and adds to the existing enrollment requirements that DMEPOS suppliers must meet to establish and maintain billing privileges in the Medicare program.

Key Points of SE1032
The *Medicare Program; Establishing Additional Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Enrollment Safeguards* rule does the following:

- Requires DMEPOS suppliers to obtain oxygen from a State-licensed oxygen supplier (applicable only to those suppliers in States that require oxygen licensure (Section 424.57(c)(27));
- Requires DMEPOS suppliers to maintain ordering and referring documentation consistent with the provisions found in Section 424.516(f) (§424.57(c)(28)). (DMEPOS supplier will be required to maintain written order from a physician or eligible professional.);
- Prohibits DMEPOS suppliers from sharing a practice location with certain other Medicare providers and suppliers (Section 424.57(c)(29));
- Requires DMEPOS suppliers to remain open to the public for at least 30 hours a week, except physician, licensed non-physician practitioners furnishing services to his or her own patient(s) as part of his or her professional service, or a DMEPOS supplier working with custom made orthotics and prosthetics (Section 424.57(c)(30)); and
- Requires DMEPOS suppliers to notify the National Supplier Clearinghouse (NSC) of an adverse legal action, change of location, or change of ownership (including authorized and delegated officials) within 30 days. Failure to notify the NSC of these changes will result in overpayments from the date of the reportable event (Section 424.57(e));
- Revises supplier standard 1 (Section 424.57(c)(1)) requiring suppliers meet all state licensure and regulatory requirements. If a State requires licensure to furnish certain items or services, a DMEPOS supplier must be licensed to provide the item or service, and must employ the licensed professional on a full-time or part time basis unless the State permits contracting for licensed services. A supplier may contract with an individual or other entity to provide licensed services unless State law expressly prohibits such an arrangement.
- Revises supplier standard 7 (Section 424.57(c)(7)) to ensure that the DMEPOS supplier maintains a physical facility on an appropriate site. The appropriate site must meet the following:

- Except for State-licensed orthotic and prosthetic personnel providing custom fabricated orthotics or prosthetics in private practice, maintain a practice location that is at least 200 square feet;
- Is in a location that is accessible to the public, Medicare beneficiaries, CMS, the NSC and its agents. The location must not be in a gated community or other area where access is restricted;
- Is accessible and staffed during posted hours of operation;
- Maintains a permanent visible sign in plain view and posts hours of operation; and
- Is in a location that contains space for storing businesses records, including the supplier's delivery, maintenance and beneficiary communication records.

- Revises supplier standard 9 (Section 424.57(c)(9)) to limit the use of cell phones, beeper numbers, and pagers as a primary business telephone number. In addition, the exclusive use of answering machines and answering services as the primary telephone number by a DMEPOS supplier during posted business hours is prohibited.

Additional Information
Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed in a timely manner for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

If you have questions related to enrollment or accrediting standards issues, please contact the NSC at (866) 238-9652 from 9 a.m. until 5 p.m. EST to reach a customer service representative.

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

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

For more information explaining the revised requirements for pharmacies as a result of Section 3109 (a) of the Patient Protection and *Affordable Care Act* you may review MM7021 at **http://www.cms.gov/MLNMattersArticles/downloads/MM7021.pdf** on the CMS website.

Also, extensive information, including a number of Frequently Asked Questions with answers, is available on the NSC website at **http://www.palmettogba.com/nsc** on the Internet.

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

MLN Matters® Number: MM6417 Revised
Related CR Release Date: December 16, 2010
Related CR Transmittal #: R825OTN

Related Change Request (CR) #: 6417
Effective Dates: Phase 1: October 5, 2009
Implementation Dates: Phase 1: October 5, 2009
Phase 2: To Be Announced

Note: *This article was revised on January 12, 2011, to clarify that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Recent revisions to CR 6417 require MACs to delay rejecting claims until receiving further direction from CMS. Some language in this article was also revised to be more aligned with language in the Change Request.*

Provider Types Affected
Physicians, non-physician practitioners, and other Part B providers and suppliers submitting claims to Carriers or Part B Medicare Administrative Contractors (MACs) for items or services that were ordered or referred. (A separate article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services

that were ordered or referred, and relates to CR 6421 at **http://www.cms.gov/MLNMattersArticles/downloads/MM6421.pdf** on the CMS website.

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

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

The providers who can order/refer are:

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

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

Key Points

- **During Phase 1 (October 5, 2009- until further notice):** When a claim is received, the MultiCarrier System (MCS) will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will continue to process but a message will be included on the remittance advice notifying the billing provider that the claims may not be paid in the future if the ordering/referring provider is not enrolled in Medicare or if the ordering/referring provider is not of the specialty eligible to order or refer.

- **During Phase 2 (Start Date to Be Announced):** If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, MCS will verify that the ordering/referring provider is on the national PECOS file. If the ordering/referring provider is not on the national PECOS file, MCS will search the contractor's master provider file for the ordering/referring provider. If the ordering/referring provider is not on the national PECOS file and is not on the contractor's master provider file, or if the ordering/referring provider is on the contractor's master provider file but is not of the specialty eligible to order or refer, the claim will not be paid.

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

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

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

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

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

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

Additional Information
You can find the official instruction, CR6417, issued to your carrier or B MAC by visiting **http://www.cms.gov/Transmittals/downloads/R825OTN.pdf** on the CMS website.
If you have any questions, please contact your carrier or B MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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

MLN Matters Number: MM6421 Revised
Related CR Release Date: December 16, 2010
Related CR Transmittal #: R823OTN

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

Note: *This article was revised on January 12, 2011, to clarify that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Recent revisions to CR 6421 required DME MACs to delay rejecting claims until receiving further direction from CMS. Some language in this article was also revised to be more aligned with language in the Change Request.*

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

Provider Action Needed
This article is based on change request (CR) 6421, which requires Medicare implementation of system edits to assure that DMEPOS suppliers bill for items or services **only** when those items or services are ordered or referred by physician and non-physician

practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact DMEPOS claims received and processed on or after October 5, 2009.

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

The providers who can order/refer are:

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

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

Key Points

- **During Phase 1 (October 5, 2009- until further notice):** When a claim is received, Medicare will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the claim, the claim will continue to process. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer, If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will also continue to process.

    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.**
    2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.**

- **During Phase 2 (Start Date to Be Announced):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. **If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.**

    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.**
    2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.**

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

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

- Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:
    - Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to **http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf** on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.
    - Checking the Ordering Referring Report at **http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage** on the CMS website.

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

Additional Information
If you have questions, please contact your Medicare DME MAC at its toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.
The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R823OTN.pdf** on the CMS website.

Face Validity Assessment of Advance Beneficiary Notice (ABN) for Complex Medical Record Review (MM6988) (GEN)

MLN Matters® Number: MM6988
Related CR Release Date: December 10, 2010
Related CR Transmittal #: R361PI
Related Change Request (CR) #: 6988
Effective Date: January 12, 2011
Implementation Date: January 12, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 6988. This CR advises contractors about the addition of Section 3.15, ABN and Complex Medical Record Review, to Chapter 3 of the *Medicare Program Integrity Manual* (PIM). This addition directs contractors to request, as part of the Additional Documentation Requests (ADRs), required ABNs when performing a complex medical record review on all claims. Please ensure that your staffs are aware of this change.

Background
Requesting required ABNs on all claims undergoing complex medical record reviews and conducting face validity assessments of mandatory ABNs will assist in ensuring that liability is assigned appropriately in accordance with the Limitation on Liability Provisions of section 1879 of the *Social Security Act*.

The instructions in the *Medicare Claims Processing Manual* Chapter 30 Section 50.6.3 address how to complete an ABN. In CR 6563, Healthcare Common Procedure Coding System (HCPCS) level 2 modifiers have been updated in order to distinguish between voluntary and required uses of liability notices. The *MLN Matters*® article related to CR 6563 may be viewed at **http://www.cms.gov/MLNMattersArticles/downloads/MM6563.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information
If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.
The official instruction, CR 6988, issued to your Medicare carrier and/or MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R361PI.pdf** on the CMS website.

Healthcare Provider Taxonomy Codes (HPTC) October 2010 Update (CEDI) (CR7130) (GEN)

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 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 3 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 October 2010 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.

Home Oxygen Use to Treat Cluster Headache (CH) (MM7235) (OXY)

MLN Matters® Number: MM7235
Related CR Release Date: January 14, 2011
Related CR Transmittal #: R130NCD

Related Change Request (CR) #: 7235
Effective Date: January 4, 2011
Implementation Date: February 15, 2011

Provider Types Affected
This article is for suppliers that bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for home use of oxygen services.

What You Need to Know
CR7235, from which this article is taken, announces that (effective for claims with dates of service on and after January 4, 2011) Medicare will allow for the coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with Cluster Headaches (CH) when these beneficiaries are enrolled in clinical studies that are approved by the Centers for Medicare & Medicaid Services (CMS) for the purpose of gaining further evidence.

Background
Medicare has a National Coverage Determination (NCD) on the home use of oxygen stating that its use is reasonable and necessary for patients with significant hypoxemia, as evidenced by a blood gas study or a measurement of arterial oxygen saturation. (Please refer to the "*Medicare NCD Manual*, Chapter 1, Part 4 ((Sections 200 – 310.1) Coverage Determinations), Section 240.2 (Home Use of Oxygen), which you can find at **http://www.cms.gov/manuals/downloads/ncd103c1_Part4.pdf** on the CMS website.

In March 2006, an internally generated NCD led to coverage of beneficiaries who were participating in clinical studies that did not qualify for coverage based on the initial criteria for hypoxemia established in the earlier NCD. (Please refer to *MLN Matters*® article MM4389 -- MMA - Coverage for Home Use of Oxygen Included in Clinical Trials, released on May 26, 2006 which you can find at **http://www.cms.gov/MLNMattersArticles/downloads/MM4389.pdf** on the CMS website.) This expansion in coverage requires that beneficiaries be enrolled subjects in National Heart, Lung, and Blood Institute-sponsored clinical trials; and the current national policy states that the home use of oxygen is reasonable and necessary for only those patients diagnosed with significant hypoxemia in conjunction with certain health conditions.

Effective for claims with dates of service on and after January 4, 2011, Medicare will allow for coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with CH when beneficiaries are enrolled in clinical studies that are approved by CMS for the purpose of gaining further evidence. Medicare will allow for coverage of beneficiaries with CH participating in an approved prospective clinical study comparing normobaric 100% oxygen with at least one clinically appropriate comparator for the treatment of CH. The clinical study must address whether home use of oxygen improves Medicare beneficiaries' health outcomes and is subject to the criteria as outlined in the *NCD Manual*, chapter 1, section 240.2.2.

DME MACs will use existing clinical trial coding conventions to help identify on a claim that the Home use of Oxygen for CH was provided pursuant to a Medicare-approved clinical study under Coverage with Evidence Development (CED). Your claims for these services must contain:

- The ICD-9-CM diagnosis codes for CH (339.00, cluster headache syndrome unspecified, 339.01, cluster headache episodic, and 339.02, cluster headache, chronic);
- HCPCS code E1399 (durable medical equipment, miscellaneous);
- Place of Service (POS) 12 (home);
- The 8-digit clinical trial number is optional;
- The Clinical Trial ICD-9-CM diagnosis code of V70.7 (Examination of participant in clinical trial); and
- The Clinical Trial Procedure Code Modifier Q0 (Investigational clinical service provided in a clinical research study that is in an approved clinical research study).

Currently, there are no clinical trials approved or pending approval for the home use of oxygen for CH. Certificates of Medical Necessity (CMNs) are not required in the context of this clinical trial setting. This is a Part B DME benefit only.

Should your DME MAC deny your claims for home use of oxygen for the treatment of CH (effective for dates of service on and after January 4, 2011) that do not conform to all of the above coding requirements, they will use following messages:

- Claim Adjustment Reason Code (CARC) 50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present;
- Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at **http://www.cms.gov/mcd/search.asp**. If you do not have web access, you may contact the contractor to request a copy of the NCD; and
- Group Code - Patient Responsibility (PR) if ABN/HINN given, otherwise Contractual Obligation (CO).

Additional Information
The official instruction, CR 7235, issued to your DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R130NCD.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.

Medicare Remit Easy Print (MREP) Enhancement (MM7218) (GEN)

MLN Matters® Number: MM7218
Related CR Release Date: November 12, 2010
Related CR Transmittal #: R811OTN

Related Change Request (CR) #: 7218
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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

What You Need to Know
The MREP software is made available to Medicare providers who may want to use the software to print their electronic remittance advice records without having to purchase software on their own. The latest enhancement to the MREP software is that, effective July 1, 2011, the software is being modified to be compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit) operating systems. If you wanted to use the MREP software, but have not done so because it was not compatible with your computer's operating system, this enhancement may make MREP a viable option for you.

Background
The Centers for Medicare and Medicaid Services (CMS) recently learned that the current version of MREP is not compatible with anything other than Microsoft XP (32 bit) operating system. Change Request (CR) 7218 will make the MREP software compatible with Microsoft Windows 7 (32 or 64 bit), Vista (32 or 64 bit), and XP (32 or 64 bit), operating systems. CMS expects that making the software compatible with multiple operating systems will make it more acceptable to users and providers/suppliers for printing their Electronic Remittance Advice (ERA) records.

Additional Information
The official instruction, CR 7218 issued to your carrier or A/B MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R811OTN.pdf** on the CMS website. To learn more about this software, visit **http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp** on the CMS website. If you have any questions, please contact your 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.

Modifications to the Implementation of the Paperwork (PWK) Segment for X12N Version 5010 (MM7306) (GEN)

MLN Matters® Number: MM7306
Related CR Release Date: January 28, 2011
Related CR Transmittal #: R849OTN

Related Change Request (CR) #: 7306
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

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 Medicare Administrative Contractors (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

What You Need to Know
This article is based on Change Request (CR) 7306, which instructs Medicare contractors about additional business requirements that are necessary to complete the implementation of the PWK segment scheduled for July 2011 under CR 7041. An article related to CR 7041 is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM7041.pdf** on the CMS website. Of significance to the provider community is a change whereby Medicare contractors will only return an incomplete/incorrect fax/mail cover sheet, when such is received. In CR 7041, the attached data was to be returned as well, but that is no longer the case. Also, note that CR 7306 requires your contractor to mask any Protected Health Information (PHI) on the fax/cover sheet returned to you.

In addition, the following changes will result from CR 7306:

- In PWK02, Medicare contractors will only use values BM and FX and will communicate that via the companion document. Other values will be accepted only in CMS-approved electronic claims attachment pilots based on agreements with willing trading partners.
- Medicare contractors will have the ability to accept the PWK02 value of EL for those contractors in a CMS-approved electronic claims attachment pilot.
- Contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be submitted when the PWK02 value is EL.

Be sure your staffs are informed of this change.

Additional Information
The official instruction, CR7306, issued to your FI, carrier, A/B MAC, and DME/MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R849OTN.pdf** on the CMS website. If you have any questions, please contact your FI, carrier, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Partial Code Freeze Prior to ICD-10 Implementation (SE1033) (GEN)

MLN Matters® Number: SE1033
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This *MLN Matters*® Special Edition Article affects all Medicare Fee-For-Service (FFS) physicians, providers, suppliers, and other entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health setting.

What You Need to Know
At the ICD-9-CM Coordination & Maintenance (C&M) Committee Meeting, held on September 15, 2010, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013.

Considerable interest was expressed in dramatically reducing the number of annual updates to both coding systems. It was suggested that such a reduction in code updates would allow vendors, providers, system maintainers, payers, and educators a better opportunity to prepare for the implementation of ICD-10. Additional public comments on this issue were received prior to this meeting.

The partial freeze will be implemented as follows:

- The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012 there will be only limited code updates to both ICD-9- CM and ICD- 10 code sets to capture new technology and new diseases.
- On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses. There will be no updates to ICD-9 -CM on October 1, 2013 as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

To view the transcript of the meeting, go to: **http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp** on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_Morning_Transcript' file. This section appears on page 4 of the 78-page document.

To view the Summary Report of the meeting, go to: **http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp** on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_ICD9_Meeting_Summary_report.pdf' file. Information on the Code Freeze begins on page 5.

Additional Information
CMS has developed a variety of educational resources to help Medicare FFS providers understand and prepare for the transition to ICD-10. General information about ICD-10 is available at **http://www.cms.gov/ICD10** on the CMS website.

In addition, the following CMS resources are available to assist in your transition to ICD-10:

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

- **CMS Sponsored National Provider Conference Calls** - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/ICD10/Tel10/list.asp#TopOfPage on the CMS website.

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

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

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

Reporting of Service Units with HCPCS (MM7247) (GEN)

MLN Matters® Number: MM7247
Related CR Release Date: December 17, 2010
Related CR Transmittal #: R2121CP
Related Change Request (CR) #: 7247
Effective Date: March 21, 2011
Implementation Date: March 21, 2011

Provider Types Affected
Providers submitting claims to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and A/B Medicare Administrative Contractors (A/B MACs) are affected by this article.

What You Need to Know
Change Request (CR) 7247 informs Medicare contractors that a table of Current Procedure Terminology (CPT) codes indicating maximum unit limitations was inadvertently deleted from Chapter 5, Section 20, of the *Medicare Claims Processing Manual*. CR 7247 reinserts that table. There are no changes to existing policy.

Additional Information
The reinserted table is at the end of the revised manual chapter attached to CR 7247. That CR is available at **http://www.cms.gov/Transmittals/downloads/R2121CP.pdf** on the CMS website. If you have any questions, please contact your FI,

RHHI, or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

CMS News Flash

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

The Centers for Medicare & Medicaid Services (CMS) has **launched the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) and is waiting to hear from you.** This survey offers Medicare Fee-For-Service (FFS) providers and suppliers an opportunity to provide feedback on interactions with their Medicare contractors. The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate will be notified starting in January. If selected to participate, please complete this important survey. To learn more about the MCPSS, please visit **http://www.cms.gov/MCPSS** on the CMS website.

Under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, which became effective on January 1, 2011, beneficiaries with Original Medicare who obtain competitively bid items in Competitive Bidding Areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. One exception occurs when an item of DMEPOS that a beneficiary already owns needs to be repaired. The "*DMEPOS Competitive Bidding Program Repairs and Replacements*" Fact Sheet contains helpful information on Competitive Bidding Program rules that apply when an item of DMEPOS that is owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services non-contract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at **http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp** on the Centers for Medicare & Medicaid Services (CMS) website, scroll down to "Downloads", and select "DMEPOS Competitive Bidding Fact Sheets".

In an effort to inform Medicare Fee-For-Service (FFS) providers about **how to avoid common billing errors and other improper activities when dealing with the Medicare Program**, the *Medicare Learning Network*® (MLN) has developed the MLN Provider Compliance web page. This page contains MLN products and *MLN Matters* articles that educate FFS providers about common billing errors and other improper activities identified through the Centers for Medicare & Medicaid Services' various claim review programs. The web page is now available at **http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp** and will be updated as new products and articles are developed and existing products and articles are revised.

Medicare Fee-For-Service (FFS) and its business associates will **implement the ASC X12, version 5010, and 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 **announced the contract suppliers for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program**. The list of contract suppliers is now available at **http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp** on the

CMS website. Visit the CMS web site at **http://www.cms.gov/DMEPOSCompetitiveBid** to view additional information on the Round 1 Rebid.

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 Learning Network*® (MLN) is now offering the "*Understanding the Remittance Advice (RA) for Institutional Providers*" **Web-Based Training (WBT)**. This WBT is designed to educate all institutional providers who bill Medicare with general RA information. It includes instructions to help you interpret the RA received from Medicare and reconcile it against submitted claims. It also provides guidance on how to read Electronic Remittance Advices and Standard Paper Remittance Advices, as well as information on balancing an RA. This activity offers continuing education and is available from the MLN at **http://www.cms.gov/MLNproducts** by scrolling to the bottom of the page and selecting Web-Based Training Modules from the Related Links Inside the Centers for Medicare & Medicaid Services (CMS) section.

The new *Medicare Learning Network*® (MLN) fact sheet "*The DMEPOS Competitive Bidding Program: Fact Sheet for Referral Agents*" is now available in both downloadable and hardcopy formats. The downloadable version is available at **http://www.cms.gov/MLNProducts/downloads/DME_Ref_Agt_Factsheet_ICN900927.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. To order a hardcopy, free of charge, please visit the MLN homepage at **http://www.cms.gov/mlngeninfo** on the Internet. Click on "MLN Product Ordering Page" in the "Related Links Inside CMS" section.

The Centers for Medicare & Medicaid Services (CMS) recently issued a **final rule that will change how Medicare pays for dialysis services for Medicare beneficiaries who have end-stage renal disease (ESRD)**. CMS also issued a proposed rule that would establish a new quality incentive program (QIP) to promote high quality services in dialysis facilities by linking a facility' s payments to performance standards. The QIP is the first pay-for-performance program in a Medicare fee-for-service payment system. For additional information please see the CMS Fact sheet (7/26) at **http://www.cms.gov/apps/media/fact_sheets.asp** on the CMS website.

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

Each Office Visit is an Opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. **Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.** 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 professionals and their staff, please visit **http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf** and **http://www.cms.gov/AdultImmunizations** on the CMS website.

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 – the influenza vaccine plus its administration are covered Part B benefits. Note that the influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care staff, please visit **http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf** and **http://www.cms.gov/AdultImmunizations** on the Centers for Medicare & Medicaid Services (CMS) website.

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.**

It's a Busy Time of Year. Make each office visit an opportunity to talk with your patients about the importance of getting the seasonal flu vaccination and a one-time pneumococcal vaccination. Remember, Medicare pays for these vaccinations for all beneficiaries with no co-pay or deductible. The seasonal flu and invasive pneumococcal disease kill thousands of people in the United States each year, most of them 65 years of age or older. The Centers for Disease Control and Prevention (CDC) also recommends that 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.** 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 professionals and their staff, please visit **http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf** and **http://www.cms.gov/AdultImmunizations** on the Centers for Medicare & Medicaid Services (CMS) website.

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.

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

Advanced Beneficiary Notice (ABN) and Complex Medical Record Review (GEN)

Effective January 12, 2011, NHIC DME MAC A Medical Review will request that any mandatory ABNs on file be submitted with all other requested documentation specified in Additional Documentation Request (ADR) letters for all complex medical reviews.

Suppliers are reminded to reference the CMS Internet Online Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, Sections 50.3.1 and 50.3.2 which states the following in regard to ABN requirements:

50.3.1 - Mandatory ABN Uses
The following are statutory provisions requiring delivery of the ABN:

- §1862(a)(1) of the Act (not reasonable and necessary);
- §1834(a)(17)(B) of the Act (violation of the prohibition on unsolicited telephone contacts);
- §1834(j)(1) of the Act (medical equipment and supplies supplier number requirements not met);
- §1834(a)(15) of the Act (medical equipment and/or supplies denied in advance).
- §1862(a)(9) of the Act (custodial care);
- §1879(g)(2) of the Act (hospice patient who is not terminally ill).

50.3.2 - Voluntary ABN Uses
ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification). However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

- Care that fails to meet the definition of a Medicare benefit as defined in §1861 of the *Social Security Act*;
- Care that is explicitly excluded from coverage under §1862 of the *Social Security Act*.
  Examples include:
  - Services for which there is no legal obligation to pay;
  - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
  - Services required as a result of war;
  - Personal comfort items;
  - Routine physicals and most screening tests;
  - Routine eye care;
  - Dental care; and
  - Routine foot care.

Suppliers are reminded that in order to avoid unnecessary denials for missing or incomplete information, please ensure when responding to an ADR that all requested information is included with your file and respond in a timely manner.

Clarification - HCPCS Code E0571 - Invalid (GEN)

Effective for dates of service on or after February 04, 2011, Healthcare Common Procedure Coding System (HCPCS) code E0571 (Aerosol compressor, battery powered, for use with small volume nebulizer) will be invalid for claim submission to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Suppliers providing battery-powered aerosol compressors should bill existing HCPCS code E0570 (Nebulizer, with compressor).

Since code E0571 is a capped rental item and for dates of service prior to February 04, 2011 is subject to least costly alternative (LCA) payment policy, claims for code E0571 will continue to have LCA applied until the 13 month capped rental payment period is completed. New initial claims for E0571 on or after February 04, 2011 will be rejected as invalid coding.

Refer to the Nebulizers local coverage determination (LCD) for additional coverage, coding and documentation requirements.

Note that products previously coded E0571 by the Pricing, Data Analysis and Coding (PDAC) contractor will be end dated on February 03, 2011 and will be listed with E0570 with an effective date of February 04, 2011. These products will be listed on the Product Classification List which is located on DME Coding System (DMECS). DMECS is located on the PDAC web site: **http://www.dmepdac.com**

Draft Glucose Monitors Local Coverage Determination Withdrawn

The DME MACs released a draft revision of the Glucose Monitors LCD for comment on September 23, 2010. The comment period ended November 08, 2010. Based upon the comments received this proposed revision has been withdrawn.

HCPCS Code E0571 – Invalid (GEN)

Effective for dates of service on or after February 04, 2011, Healthcare Common Procedure Coding System (HCPCS) code E0571 (Aerosol compressor, battery powered, for use with small volume nebulizer) will be invalid for claim submission to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Suppliers providing battery-powered aerosol compressors should bill existing HCPCS code E0570 (Nebulizer, with compressor).

Refer to the *Nebulizers local coverage determination* (LCD) for additional coverage, coding and documentation requirements.

Products previously coded E0571 by the Pricing, Data Analysis and Coding (PDAC) contractor will be end dated on February 03, 2011 and will be listed with E0570 with an effective date of February 04, 2011. These products will be listed on the Product Classification List which is located on DME Coding System (DMECS). DMECS is located on the PDAC web site, **http://www.dmepdac.com**

HCPCS Code Update – 2011 (GEN)

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2011. Please refer to Change Requests 7064 and 7121 published on the Centers for Medicare and Medicaid (CMS) web site.

Added Codes/Added Modifiers: New codes and modifiers are effective for dates of service on or after January 1, 2011.

Discontinued Codes/Deleted Modifiers: Codes or modifiers that are discontinued / deleted will continue to be valid for claims with dates of service on or before December 31, 2010, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2011.

Narrative Changes/Revised Modifiers: A description change for an existing code or modifier is effective for dates of service on or after January 1, 2011.

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

Ankle-Foot/Knee-Ankle-Foot Orthoses

	Added Code
Code	**Narrative**
L4631	ANKLE FOOT ORTHOSIS, WALKING BOOT TYPE, VARUS/VALGUS CORRECTION, ROCKER BOTTOM, ANTERIOR TIBIAL SHELL, SOFT INTERFACE, CUSTOM ARCH SUPPORT, PLASTIC OR OTHER MATERIAL, INCLUDES STRAPS AND CLOSURES, CUSTOM FABRICATED

Enteral Nutrition

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

External Infusion Pumps

	Added Code
Code	**Narrative**
J1559	INJECTION, IMMUNE GLOBULIN (HIZENTRA), 100 MG

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
J9110	INJECTION, CYTARABINE, 500 MG	J9100
J9375	VINCRISTINE SULFATE, 2 MG	J9370
J9380	VINCRISTINE SULFATE, 5 MG	J9370

Home Dialysis Supplies and Equipment

	INVALID FOR SUBMISSION TO DME MAC
Code	**Narrative**
A4651	CALIBRATED MICROCAPILLARY TUBE, EACH
A4652	MICROCAPILLARY TUBE SEALANT
A4653	PERITONEAL DIALYSIS CATHETER ANCHORING DEVICE, BELT, EACH
A4671	DISPOSABLE CYCLER SET USED WITH CYCLER DIALYSIS MACHINE, EACH

	INVALID FOR SUBMISSION TO DME MAC
Code	**Narrative**
A4672	DRAINAGE EXTENSION LINE, STERILE, FOR DIALYSIS, EACH
A4673	EXTENSION LINE WITH EASY LOCK CONNECTORS, USED WITH DIALYSIS
A4674	CHEMICALS/ANTISEPTICS SOLUTION USED TO CLEAN/STERILIZE DIALYSIS EQUIPMENT, PER 8 OZ
A4680	ACTIVATED CARBON FILTER FOR HEMODIALYSIS, EACH
A4690	DIALYZER (ARTIFICIAL KIDNEYS), ALL TYPES, ALL SIZES, FOR HEMODIALYSIS, EACH
A4706	BICARBONATE CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4707	BICARBONATE CONCENTRATE, POWDER, FOR HEMODIALYSIS, PER PACKET
A4708	ACETATE CONCENTRATE SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4709	ACID CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON
A4714	TREATED WATER (DEIONIZED, DISTILLED, OR REVERSE OSMOSIS) FOR PERITONEAL DIALYSIS, PER GALLON
A4719	"Y SET" TUBING FOR PERITONEAL DIALYSIS
A4720	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 249CC, BUT LESS THAN OR EQUAL TO 999CC, FOR PERITONEAL DIALYSIS
A4721	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 999CC BUT LESS THAN OR EQUAL TO 1999CC, FOR PERITONEAL DIALYSIS
A4722	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 1999CC BUT LESS THAN OR EQUAL TO 2999CC, FOR PERITONEAL DIALYSIS
A4723	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 2999CC BUT LESS THAN OR EQUAL TO 3999CC, FOR PERITONEAL DIALYSIS
A4724	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 3999CC BUT LESS THAN OR EQUAL TO 4999CC, FOR PERITONEAL DIALYSIS
A4725	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 4999CC BUT LESS THAN OR EQUAL TO 5999CC, FOR PERITONEAL DIALYSIS
A4726	DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 5999CC, FOR PERITONEAL DIALYSIS
A4728	DIALYSATE SOLUTION, NON-DEXTROSE CONTAINING, 500 ML
A4730	FISTULA CANNULATION SET FOR HEMODIALYSIS, EACH
A4736	TOPICAL ANESTHETIC, FOR DIALYSIS, PER GRAM
A4737	INJECTABLE ANESTHETIC, FOR DIALYSIS, PER 10 ML
A4740	SHUNT ACCESSORY, FOR HEMODIALYSIS, ANY TYPE, EACH
A4750	BLOOD TUBING, ARTERIAL OR VENOUS, FOR HEMODIALYSIS, EACH
A4755	BLOOD TUBING, ARTERIAL AND VENOUS COMBINED, FOR HEMODIALYSIS, EACH
A4760	DIALYSATE SOLUTION TEST KIT, FOR PERITONEAL DIALYSIS, ANY TYPE, EACH
A4765	DIALYSATE CONCENTRATE, POWDER, ADDITIVE FOR PERITONEAL DIALYSIS, PER PACKET
A4766	DIALYSATE CONCENTRATE, SOLUTION, ADDITIVE FOR PERITONEAL DIALYSIS, PER 10 ML
A4770	BLOOD COLLECTION TUBE, VACUUM, FOR DIALYSIS, PER 50
A4771	SERUM CLOTTING TIME TUBE, FOR DIALYSIS, PER 50
A4772	BLOOD GLUCOSE TEST STRIPS, FOR DIALYSIS, PER 50
A4773	OCCULT BLOOD TEST STRIPS, FOR DIALYSIS, PER 50
A4774	AMMONIA TEST STRIPS, FOR DIALYSIS, PER 50
A4802	PROTAMINE SULFATE, FOR HEMODIALYSIS, PER 50 MG
A4860	DISPOSABLE CATHETER TIPS FOR PERITONEAL DIALYSIS, PER 10
A4870	PLUMBING AND/OR ELECTRICAL WORK FOR HOME HEMODIALYSIS EQUIPMENT
A4890	CONTRACTS, REPAIR AND MAINTENANCE, FOR HEMODIALYSIS EQUIPMENT
A4911	DRAIN BAG/BOTTLE, FOR DIALYSIS, EACH
A4913	MISCELLANEOUS DIALYSIS SUPPLIES, NOT OTHERWISE SPECIFIED
A4918	VENOUS PRESSURE CLAMP, FOR HEMODIALYSIS, EACH
A4928	SURGICAL MASK, PER 20
A4929	TOURNIQUET FOR DIALYSIS, EACH
E1500	CENTRIFUGE, FOR DIALYSIS

	INVALID FOR SUBMISSION TO DME MAC
Code	**Narrative**
E1510	KIDNEY, DIALYSATE DELIVERY SYST. KIDNEY MACHINE, PUMP RECIRCULAT- ING, AIR REMOVAL SYST, FLOWRATE METER, POWER OFF, HEATER AND TEMPERATURE CONTROL WITH ALARM, I.V.POLES, PRESSURE GAUGE, CONCENTRATE CONTAINER
E1520	HEPARIN INFUSION PUMP FOR HEMODIALYSIS
E1530	AIR BUBBLE DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT
E1540	PRESSURE ALARM FOR HEMODIALYSIS, EACH, REPLACEMENT
E1550	BATH CONDUCTIVITY METER FOR HEMODIALYSIS, EACH
E1560	BLOOD LEAK DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT
E1570	ADJUSTABLE CHAIR, FOR ESRD PATIENTS
E1575	TRANSDUCER PROTECTORS/FLUID BARRIERS, FOR HEMODIALYSIS, ANY SIZE, PER 10
E1580	UNIPUNCTURE CONTROL SYSTEM FOR HEMODIALYSIS
E1590	HEMODIALYSIS MACHINE
E1592	AUTOMATIC INTERMITTENT PERITIONEAL DIALYSIS SYSTEM
E1594	CYCLER DIALYSIS MACHINE FOR PERITONEAL DIALYSIS
E1600	DELIVERY AND/OR INSTALLATION CHARGES FOR HEMODIALYSIS EQUIPMENT
E1610	REVERSE OSMOSIS WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS
E1615	DEIONIZER WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS
E1620	BLOOD PUMP FOR HEMODIALYSIS, REPLACEMENT
E1625	WATER SOFTENING SYSTEM, FOR HEMODIALYSIS
E1630	RECIPROCATING PERITONEAL DIALYSIS SYSTEM
E1632	WEARABLE ARTIFICIAL KIDNEY, EACH
E1634	PERITONEAL DIALYSIS CLAMPS, EACH
E1635	COMPACT (PORTABLE) TRAVEL HEMODIALYZER SYSTEM
E1636	SORBENT CARTRIDGES, FOR HEMODIALYSIS, PER 10
E1637	HEMOSTATS, EACH
E1699	DIALYSIS EQUIPMENT, NOT OTHERWISE SPECIFIED

Intravenous Immune Globulin

	Added Code
Code	**Narrative**
J1599	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG

Lower Limb Prostheses

	Added Code
Code	**Narrative**
L5961	ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL

Mechanical In-Exsufflation Devices

	Added Code
Code	**Narrative**
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY

Miscellaneous

	Added Code
Code	**Narrative**
A4566	SHOULDER SLING OR VEST DESIGN, ABDUCTION RESTRAINER, WITH OR WITHOUT SWATHE CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (*Note: Noncovered; No benefit category*)
A9273	HOT WATER BOTTLE, ICE CAP OR COLLAR, HEAT AND/OR COLD WRAP, ANY TYPE (*Note: Noncovered; No benefit category)*

	Added Code
Code	**Narrative**
E1831	STATIC PROGRESSIVE STRETCH TOE DEVICE, EXTENSION AND/OR FLEXION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES
L3674	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITH OR WITHOUT NONTORSION JOINT/TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
L3671	SHOULDER ORTHOSIS, SHOULDER CAP DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
L3677	SHOULDER ORTHOSIS, HARD PLASTIC, SHOULDER STABILIZER, PRE-FABRICATED, INCLUDES FITTING AND ADJUSTMENT	SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
E0220	HOT WATER BOTTLE	A9273
E0230	ICE CAP OR COLLAR	A9273
E0238	NON-ELECTRIC HEAT PAD, MOIST	A9273
L3672	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INLCUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3674
L3673	SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, INCLUDES NONTORSION JOINT/TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT	L3674

Nebulizers

	Added Code
Code	**Narrative**
J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A7013	FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR	FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR OR ULTRASONIC GENERATOR

Ostomy Supplies

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A4399	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER, INCLUDING BRUSH	OSTOMY IRRIGATION SUPPLY; CONE/CATHETER, WITH OR WITHOUT BRUSH

Oxygen

	Added Code
Code	**Narrative**
E0446	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES (*Note: Denied as not medically necessary; National Coverage Determination 20.29[C]*)

Surgical Dressings

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A6011	COLLAGEN BASED WOUND FILLER, GEL/PASTE, STERILE, PER GRAM OF COLLAGEN	COLLAGEN BASED WOUND FILLER, GEL/PASTE, PER GRAM OF COLLAGEN
A6248	HYDROGEL DRESSING, WOUND FILLER, GEL, STERILE, PER FLUID OUNCE	HYDROGEL DRESSING, WOUND FILLER, GEL, PER FLUID OUNCE
A6260	WOUND CLEANSERS, STERILE, ANY TYPE, ANY SIZE	WOUND CLEANSERS, ANY TYPE, ANY SIZE
A6261	WOUND FILLER, GEL/PASTE, STERILE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED	WOUND FILLER, GEL/PASTE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED
A6262	WOUND FILLER, DRY FORM, STERILE, PER GRAM, NOT OTHERWISE SPECIFIED	WOUND FILLER, DRY FORM, PER GRAM, NOT OTHERWISE SPECIFIED

Urological Supplies

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
A5112	URINARY LEG BAG; LATEX	URINARY DRAINAGE BAG, LEG OR ABDOMEN, LATEX, WITH OR WITHOUT TUBE, WITH STRAPS, EACH

Wheelchair Seating

	Added Code
Code	**Narrative**
E2622	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2623	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH
E2624	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH
E2625	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH

	Discontinued Code	
Code	**Narrative**	**Crosswalk to Code**
K0734	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	E2622
K0735	SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	E2623
K0736	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH	E2624
K0737	SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH	E2625

Modifiers

	Added Code
Code	**Narrative**
AY	ITEM OR SERVICE FURNISHED TO AN ESRD PATIENT THAT IS NOT FOR THE TREATMENT OF ESRD
CS	ITEM OR SERVICE RELATED, IN WHOLE OR IN PART, TO AN ILLNESS, INJURY, OR CONDITION THAT WAS CAUSED BY OR EXACERBATED BY THE EFFECTS, DIRECT OR INDIRECT, OF THE 2010 OIL SPILL IN THE GULF OF MEXICO, INCLUDING BUT NOT LIMITED TO SUBSEQUENT CLEAN-UP ACTIVITIES
GU	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, ROUTINE NOTICE

	Added Code
Code	**Narrative**
NB	NEBULIZER SYSTEM, ANY TYPE, FDA-CLEARED FOR USE WITH SPECIFIC DRUG

	Narrative Changes	
Code	**Old Narrative**	**New Narrative**
GA	WAIVER OF LIABILITY STATEMENT ON FILE	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, INDIVIDUAL CASE

Heating Pads and Heat Lamps - Draft Medical Policy Finalized (GEN)

The draft Local Coverage Determination and Policy Article for Heating Pads and Heat Lamps has been finalized. The medical policy is effective for claims with dates of service on or after April 1, 2011.

Products that are currently coded E0210, E0215, E0217, or E0249 by the Pricing, Data Analysis and Coding (PDAC) contractor and are listed in the DME Coding System (DMECS) Product Classification List on the PDAC web site will be end-dated on March 31, 2011. Although Coding Verification Review by the PDAC is not required for suppliers to bill these products, manufacturers who want their product(s) listed in DMECS after April 1, 2011 will need to submit a new application.

The PDAC coding verification review application required for these products is the DME and Supplies application. This application is located on the PDAC web site: **https://www.dmepdac.com/review/apps_check.html**. If you have questions, please contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC web site: **https://www.dmepdac.com**

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

Home Dialysis and Epoetin - Medical Policies Retired (GEN)

Effective for claims with dates of service on or after January 1, 2011, Method II home dialysis is no longer an option. All claims for home dialysis and related Epoetin use will be submitted to the Medicare Part A/B contractors. Therefore, the DME MAC Local Coverage Determinations and Policy Articles for Home Dialysis Supplies and Equipment and for Epoetin will be retired with an ending date of December 31, 2010.

LCD and Policy Article Revisions - Summary for December 2010

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

Ankle-Foot / Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Added: Statement from policy article regarding routine replacement of components.
- Deleted: Least costly alternative for custom fabricated orthoses

HCPCS CODES AND MODIFIERS (Effective 1/1/2011):

- Added: Code L4631
- Revised: GA modifier

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

- Added: Code L4631 and ICD-9 code 713.5

Policy Article

Revision Effective Date: 02/04/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added: Preamble language
- Revised: Clarified noncoverage statements for L4392, L4394, L4396 and L4398

CODING GUIDELINES:

- Added: Definition of L4631
- Revised: Clarified proper coding instructions based on brace use

Canes and Crutches

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Revised: Preamble language
- Deleted: Least costly alternative language for code E0117

Cervical Traction Devices

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Deleted: Least costly alternative for multiple codes

HCPCS CODES AND MODIFIERS:

- Revised: GA modifier

Commodes

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative language for code E0168
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Enteral Nutrition

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for special enteral formulas and supply kits
HCPCS CODES AND MODIFIERS:
Revised: B4034, B4035, B4036

External Breast Prosthesis

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:
Added: 198.81, 457.0, V10.3 as covered indications
Deleted: Least costly alternative for multiple codes
COVERED ICD-9 CODES:
Added: 198.81, 457.0, V10.3

Policy Article

Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY AND COVERAGE AND PAYMENT RULES:
Added: Preamble language
CODING GUIDELINES
Revised: RT/LT modifier instructions for inherently bilateral items.

External Infusion Pumps

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: The least costly alternative Language for E0779
Added: Coverage for Hizentra (J1559) effective 04/04/2010, coverage for Gamunex (J1561) effective 10/13/2010) to subcutaneous immune globulin section
HCPCS CODES AND MODIFIERS: (effective 01/01/2011 except as noted)
Revised: GA modifier verbiage
Added: J1559
Added: J1561 (effective 10/13/2010)
Added: JB modifier
Deleted: J9110, J9375, and J9380
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: J1559, J1561
DOCUMENTATION REQUIREMENTS: (effective 01/01/2011)
Added: JB modifier

Glucose Monitors

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Preamble language
Deleted: Least costly alternative language for codes E2100 and E2101
Deleted: Least costly alternative language for codes E0620 and A4257

Note: *This is NOT a release of the draft Glucose Monitors policy that was recently out for comment. This is a revision to the existing policy.*

Hospital Beds

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

DELETED: Least costly alternative language

HCPCS CODES AND MODIFIERS:

Revised: GA modifier

Knee Orthosis

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative for multiple HCPCS codes

HCPCS CODES AND MODIFIERS:

Added: Code L4002

Revised: GA modifier

ICD-9 COES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-9 code 844.8 for codes L1830, L1832, L1834, and L1843-L1846

Policy Article

Revision Effective Date: 02/04/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble language

CODING GUIDELINES:

Added: Code L4002 to correct coding tables

Added: Instructions for L4002

Manual Wheelchairs

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative language for K0002 - K0007

HCPCS CODES AND MODIFIERS:

Revised: GA modifier

Nebulizers

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Coverage for treprostinil inhalation solution

Revised: Coverage of E0574, E0575

Deleted: References to code E0571

HCPCS CODES AND MODIFIERS (Effective 1/1/2011):

Added: J7686

Revised: J7013

Revised: GA modifier

Deleted: E0571

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: A7013, A7014, A7016, E0574, J7686 to pulmonary hypertension ICD-9 code

Deleted: Code E0574 from COPD code set

Deleted: Code E0571

Policy Article

Revision Effective Date: 02/04/2011

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble language

Added: Noncoverage statement for nebulizer used to administer aztreonam lysine and related accessories

CODING GUIDELINES:

Added: Coding information for nebulizer used to administer aztreonam lysine inhalation solution and related accessories.
Added: Coding verification review for E0574 ultrasonic nebulizers (Effective for DOS on or after 4/1/2011)
Added: Code E0571 invalid for DME MAC submission
Revised: Definition of E0570 to include battery-powered aerosol compressors

Patient Lifts

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Removed: Least costly alternative language for E0636, E0135, and E0136.
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Pneumatic Compression Devices

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least Costly Alternative for HCPCPS code E0652

Positive Airway Pressure Devices

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for codes E0470 and E0471
HCPCS CODES AND MODIFIERS:
Revised: GA modifier
DOCUMENTATION REQUIREMENTS:
Revised: Requirements for documenting ineffective therapy on E0601

Power Mobility Devices

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Coverage criteria relating to patient weight for POVs and PWCs
Deleted: Least costly alternative language for multiple codes.
Moved: Denial information on Group 2 POVs, Group 2 PWCs with Seat Elevators, and Group 4 PWCs to the Policy Article
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Policy Article

Revision Effective Date: 02/04/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Added: Noncoverage statement for Group 2 POVs, Group 2 PWCs with Seat Elevators, and Group 4 PWCs

Respiratory Assist Devices

LCD

Revision Effective Date: 02/04/2011
INDICATIONS AND LIMITATIONS OF COVERAGE:
Deleted: Least costly alternative language for E0471
HCPCS CODES AND MODIFIERS:
Revised: GA modifier

Seat Lift Mechanisms

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative language for E0627.

Surgical Dressings

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative for HCPCS codes A6228-A6230

HCPCS CODES: (effective 1/01/2011)

Revised: A6011, A6248, A6260-A6262

Tracheostomy Supplies

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least Costly Alternative for A4625

Therapeutic Shoes

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Denial statements for custom fabricated shoes

DOCUMENTATION REQUIREMENTS:

Added: Statement about timing of detailed written order. (Effective 1/1/2011)

Added: Clarification about documentation that must be in the certifying physician's records.

Added: Documentation required at the time of selecting the shoes/inserts. (Effective 7/1/2010)

Added: Documentation required at the time of delivery. (Effective 7/1/2010)

Urological Supplies

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative language for multiple codes

Revised: Coverage of A4336

Added: A5105 to list of codes used with A5131

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY

Added: 625.6 for HCPCS A4336

Policy Article

Revision Effective Date: 02/04/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Preamble language

CODING GUIDELINES:

Revised: A4253 definition

Revised: bundling table instructions

Deleted: A4353 from table

Walkers

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative language for heavy-duty walkers, E0147 walkers, and walkers with an enclosed frame or trunk support.

HCPCS CODES AND MODIFIERS:

Revised: GA modifier

Wheelchair Options and Accessories

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Deleted: Least costly alternative language for dual mode battery chargers

HCPCS CODES AND MODIFIERS:

Revised: GA modifier

Policy Article

Revision Effective Date: 01/01/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Introductory statement concerning content of Policy Articles.

CODING GUIDELINES:

Revised: Instructions for use of the RT and LT modifiers when unit of service is "pair".

Clarified: Billing instructions for expandable controllers (E2377, E2376), electronic harnesses (E2313), and special features of joysticks.

Added: Statement that E1028 is not separately billable with a wheelchair tray and added E0950 to bundling table

Wheelchair Seating

LCD

Revision Effective Date: 02/04/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Denial statements for general use cushions used with power wheelchairs with sling/solid seats/backs, for skin protection, positioning and combination seat cushions, for positioning back cushions, and for custom fabricated cushions.

HCPCS CODES AND MODIFIERS: (effective 01/01.2011)

Added: E2622 - E2625

Revised: GA

Deleted: K0734 - K0737

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Replaced: K0734-K0737 with E2622-E2625

DOCUMENTATION REQUIREMENTS:

Replaced: K0734-K0737 with E2622-E2625

Policy Article

Revision Effective Date: 01/01/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Introductory statement concerning content of Policy Articles.

CODING GUIDELINES:

Replaced: K0734-K0737 with E2622-E2625

LCD and Policy Article Revisions - Summary for February 17, 2011

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 Appliances for Obstructive Sleep Apnea

LCD

Revision Effective Date: 01/03/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Corrected: Clerical error in the coverage criterion for Severe OSA (Was listed as criterion C. should have been B 3)

Suction Pumps

LCD

Revision Effective Date: 03/01/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Replaced: A4624 with A4628 in reference to re-use of catheter

Wheelchair Options/Accessories

Policy Article

Revision Effective Dated: 03/01/2011

CODING GUIDELINES:

Clarified: billing instructions for Power Wheelchairs for armrests versus separate billing for detachable adjustable height armrests (K0017 and K0018).

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.*

Local Coverage Determinations - Elimination of Least Costly Alternative (GEN)

CMS has instructed contractors that they may no longer make partial payment for claims based on a "least costly alternative" (LCA) determination. Therefore, for claims with dates of service on or after February 04, 2011, the following rules apply under this new guidance:

- If the local coverage determination (LCD) currently states that an item will always be paid based on the allowance for the least costly item (if the criteria for the less costly item are met), then under the new policy a claim for that item will always be denied as not medically necessary. (Type 1 LCA denial)
- If the LCD currently states that an item will be paid in full if specific additional coverage criteria are met but will be paid based on the allowance for the least costly item if the additional coverage criteria for the billed item are not met (and if the criteria for the less costly item are met), then under the new policy a claim for that item will be denied as not medically necessary if all of the additional coverage criteria for that item are not met. (Type 2 LCA denial)
    - The claim will be paid in full if the additional coverage criteria are met.
    - If a KX modifier is required to attest to the additional coverage criteria being met, claims without a KX modifier (and with a GA, GY, or GZ modifier) will be denied.

If a base code for an item of durable medical equipment, prosthesis, or orthosis is denied as not medically necessary, all related accessories, supplies, additions, and drugs will be denied as not medically necessary.

Least costly alternative statements are found in the following LCDs (Note: The information may not be all-inclusive; refer to each LCD for details.):

- Ankle-Foot/Knee-Ankle-Foot Orthoses
    - Custom fabricated AFOs/KAFOs (L1900, L1904, L1907, L1920, L1940-L1950, L1960, L1970, L1980-L2034, L2036-L2108, L2126, L2128)(Type 2)
- Canes and Crutches
    - Underarm articulating spring assisted crutch (E0117) (Type 1)
- Cervical Traction Devices
    - Cervical traction by headboard attachment (E0840) (Type 1)
    - Cervical traction by freestanding frame (E0850) (Type 1)
    - Cervical traction, free standing stand/frame, traction force to other than mandible (E0849) (Type 2)
    - Cervical traction, not requiring stand/frame (E0855) (Type 2)
- Commodes
    - Commode - extra wide/heavy duty (E0168) (Type 2)

- Enteral Nutrition
  - Special enteral nutrients (B4149,B4153-B4157,B4161,B4162) (Type 2)
  - Pump supply kit (B4035) (Type 2)
- External Breast Prostheses
  - Breast prostheses, silicone or equal, with integral adhesive (L8031) (Type 1)
  - Custom fabricated breast prosthesis (L8035) (Type 1)
- External Infusion Pumps
  - Infusion pump used with subcutaneous immune globulin (E0781, E0791) (Type 1)
- Glucose Monitors
  - Glucose monitors with special features (E2100, E2101) (Type 2)
  - Laser lancing device and lens shield cartridge (E0620, A4257) (Type 1)
- Hospital Beds
  - Total electric hospital bed (E0265, E0266, E0296, E0297) (Type 1)
  - Other hospital beds (E0255-E0261, E0292-E0295, E0301-E0304, E0329) (Type 2)
- Knee Orthoses
  - Knee orthosis with inflatable bladder (L1847) (Type 1)
  - Custom fabricated orthoses (L1834, L1840, L1844, L1846, L1860) (Type 2)
- Manual Wheelchairs
  - Manual wheelchairs (K0002 - K0007) (Type 2)
- Nebulizer Equipment and Related Drugs
  - Small volume ultrasonic nebulizer (E0574) (Type 1)
  - Battery-powered nebulizer (E0571) (Type 1) (Exception: Coding for these items is being changed.)
  - Controlled dose delivery system (K0730) (Type 2)
- Patient Lifts
  - Patient support system with integrated lift (E0636) (Type 2)
  - Multipositional patient transfer systems (E1035, E1036) (Type 2)
- Pneumatic Compression Devices
  - Segmented device with manual chamber control (E0652) (Type 2)
- Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea
  - Bi-level without backup (E0470) (Type 2)
  - Bi-level with backup used for OSA (E0471) (Type 1)
- Power Mobility Devices
  - Power operated vehicles - Group 1 (K0801, K0802) (Type 2)
  - Power operated vehicles - Group 2 (K0806 - K0808) (Type 1) (Exception: Will be denied as statutorily noncovered.)
  - Power wheelchairs - Group 2 with seat elevator and Group 4 (K0830, K0831, K0868 - K0886) (Type 1) (Exception: Will be denied as statutorily noncovered.)
  - Power wheelchairs - Groups 1, 2, 3, and 5 (K0813 - K0829, K0835 - K0864, K0890, K0891) (Type 2)
- Respiratory Assist Devices
  - Bi-level with backup rate (E0471) (Type 2)
- Seat Lift Mechanisms
  - Seat lift mechanism incorporated into chair (E0627) (Type 1) (Exception: E0627 will be paid in full.)
- Surgical Dressings
  - Water or saline impregnated gauze (A6228-A6230) (Type 1)
- Therapeutic Shoes for Persons with Diabetes
  - Custom fabricated shoes (A5501) (Type 2)
- Tracheostomy Supplies
  - Tracheostomy starter kit (A4625) (Type 2)
- Urological Supplies
  - Specialty indwelling catheter (A4340) (Type 2)
  - All silicone catheter (A4344, A4312, or A4315) (Type 2)
  - Three way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) (Type 2)
  - Drainage bags containing gel matrix or other material (Type 1)
  - Coude (curved) tip catheter (A4352) (Type 2)
  - Specialty type male external catheters (A4326) (Type 2)
  - Catheter/tube anchoring device (A5200) (Type 2)

- Walkers
  - Heavy duty walker (E0148, E0149) (Type 2)
  - Heavy duty, multiple braking system, variable wheel resistance walker (E0147) (Type 2)
  - Walker with an enclosed frame (E0144) (Type 1)
  - Walker with trunk support (E0140) (Type 2)
- Wheelchair Options and Accessories
  - Dual mode battery charger (E2367) (Type 1)
- Wheelchair Seating
  - General use seat and back cushion (when used with power WC with sling/solid seat) (Type 2)
  - Skin protection seat cushion, positioning seat cushion, or combination skin protection and positioning seat cushion (E2603-E2608, E2613-E2616, E2620, E2621, E2622-E2625) (Type 2)
  - Positioning back cushion (E2613-E2616, E2620, E2621) (Type 2)
  - Custom fabricated cushion (E2609, E2617) (Type 2)

Revisions of these LCDs incorporating these changes are being published - refer to the individual policies for details.

For capped rental DME items, elimination of LCA determinations will apply only to claims in which the date of service (DOS) for the initial rental month is on or after February 04, 2011. If an LCA determination is made on an item with an initial rental month DOS prior to February 04, 2011, subsequent claims for that item will continue to be adjudicated using the LCA determination for the duration of that rental period.

If an item is denied in full due to elimination of LCA, partial payment based on LCA will not be possible through the appeals process.

For items that were previously paid based on an LCA determination, suppliers can receive partial payment at the time of initial determination if they elect to bill using one of the upgrade modifiers, GK or GL. Refer to the related article titled *Use of Upgrade Modifiers*.

Further instructions will be forthcoming concerning the options that a supplier has if a claim is submitted without upgrade modifiers and is denied as not medically necessary and the supplier subsequently decides that it would like to utilize the upgrade modifiers.

Nebulizers Widespread Review: Notification of Continuation of Complex Review (SPE)

NHIC recently conducted a widespread prepayment review on HCPCS Code

E0570 (NEBULIZER, WITH COMPRESSOR)

The results of the review were posted on the NHIC web site on November 11, 2010. In the review, 211 services were reviewed with 143 being denied, resulting in a 68.3% Charge Denial Rate. Based on the outcome of the review, NHIC will continue with a widespread complex review on claims billed with HCPCS Code E0570.

Suppliers are reminded they will receive an Additional Documentation Request (ADR) letter asking for specific information to determine if the item billed complies with the existing reasonable and necessary criteria. Failure to supply the requested information within 30 days of the date on the letter may result in claim denial.

It is important for suppliers to be familiar with documentation requirements outlined in the *Nebulizers LCD* (L11499) and related Policy Article on the NHIC web site at: **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

Negative Pressure Wound Therapy - LCD Documentation (GEN)

Suppliers of Negative Pressure Wound Therapy (NPWT) claims are reminded that there are stringent documentation requirements in the local coverage determination (LCD). Elements of the LCD that require information from the medical record to justify coverage include:

- Complete description of the wound
- Description of prior care for the wound
- Complications with surgically-created wounds
- Monthly monitoring of wound healing progress
- Need for more than four months therapy
- Need for a quantity of supplies that exceeds the expected amounts outlined in the LCD

Suppliers should review the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for a complete discussion of coverage criteria.

As noted in the "Documentation Requirements" section of the LCD, the following types of information may be requested in the event of a claim review:

Documentation of the history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being billed must be present in the patient's medical record and be available for review if requested. This documentation must include such elements as length of sessions of use, dressing types and frequency of change, and changes in wound conditions, including precise measurements, quantity of exudates, presence of granulation and necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.).

Documentation of wound evaluation and treatment, recorded in the patient's medical record, must indicate regular evaluation and treatment of the patient's wounds, as detailed in the Indications and Limitations of Coverage Section. Documentation of quantitative measurements of wound characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage), indicating progress of healing must be entered at least monthly. ***The supplier of the NPWT equipment and supplies must obtain from the treating clinician, an assessment of wound healing progress, based upon the wound measurement as documented in the patient's medical record, in order to determine whether the equipment and supplies continue to qualify for Medicare coverage.*** *(The supplier need not view the medical records in order to bill for continued use of NPWT. Whether the supplier ascertains that wound healing is occurring from month to month via verbal or written communication is left to the discretion of the supplier. However, the patient's medical records may be requested in order to corroborate that wound healing is/was occurring as represented on the supplier's claims for reimbursement.)*

Suppliers should note the highlighted statement from the Documentation Section requiring frequent contact with the treating clinician to assess the continued need for therapy.

Suppliers should refer to the *Supplier Manual*, LCD and Policy Article for additional information on NPWT and other general documentation requirements.

New Modifier CS - Effective Date April 10, 2010 (GEN)

Modifier "CS" is a new modifier that was created to identify items or services related to the treatment of illnesses, injuries, or conditions caused or exacerbated, directly or indirectly, by the 2010 oil spill in the Gulf of Mexico. As noted in Transmittal 2021 (CR 7087), contractors will accept modifier CS on all claims for such items or services for dates of service on or after April 10, 2010. The Calendar Year (CY) 2011 Healthcare Common Procedure Codes System (HCPCS) file erroneously listed modifier CS with an effective date of January 01, 2011.

If you have questions, please contact the PDAC Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC web site: **https://www.dmepdac.com/**

Parenteral Nutrition - Least Costly Medically Appropriate Alternative Eliminated (PEN)

CMS has instructed contractors that they may no longer make partial payment for claims based on a "least costly alternative" (LCA) determination. In December 2010, the DME MACs released revisions to LCDs containing LCA provisions. The Parenteral Nutrition LCD was not included in that release.

It was discovered that the Parenteral Nutrition LCD might be considered as having an LCA provision. The Parenteral Nutrition LCD contains the following statement:

> "Special parenteral formulas (B5000-B5200) are rarely medically necessary. If the medical necessity for these formulas is not substantiated, payment will be made for the medically appropriate formula."

While this passage does not explicitly say "paid at LCA", in most cases the medically appropriate formula is a standard nutrient solution which is less costly. Therefore, it was felt that it would be appropriate to revise the passage. The revised section states:

> "The medical necessity for special enteral formulas (B5000-B5200) must be justified in each patient. If a special parenteral nutrition formula is provided and if the medical record does not document why that item is reasonable and necessary, it will be denied as not reasonable and necessary."

A revised LCD will be released via our list-serves. The revised LCD will be effective for dates of service on or after 2/4/2011.

Positive Airway Pressure (PAP) Devices - Interpreting Physician Credentials (GEN)

Recently questions have arisen regarding how suppliers should verify the credentials of the physician interpreting sleep tests when requested during the course of a contractor's claim review. As noted in the local coverage determination (LCD) for Positive Airway Pressures (PAP) Devices:

For PAP devices with initial dates of service on or after November 1, 2008, all HSTs (Type II, III, IV, Other) must be interpreted by a physician who holds either:

1. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or,
2. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or,
3. Completed residency or fellowship training by an ABMS member board and has completed all the requirements for subspecialty certification in sleep medicine except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or,
4. Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations - JCAHO).

For PAP devices with coverage based on a facility-based polysomnogram (Type I) performed on or after January 1, 2010, the interpreting physician must meet one of the requirements listed above (1-4) for credentialing.

There are multiple methods for confirming the interpreting physician's credentials. One method is to request a copy of the board certificate or other documentation provided by the certifying entity directly from the physician. Alternatively, there are several web sites that have credential verification information. Suppliers may provide screen prints from one of these sites with information about the

interpreting physician's credentialing status. The following list contains examples (not all-inclusive) of web sites and organizations that maintain this information:

1. For physicians affiliated with an American Academy of Sleep Medicine (AASM)-accredited sleep lab – **http://www.sleepcenters.org**

2. Board certification entities
    a. American Board of Sleep Medicine (ABSM) (for those certified prior to 2007) - Certification by ABSM was not time-limited (i.e., lifetime certification) so ABSM still maintains a site with credentials verification information at www.absm.org.
    b. American Board of Medical Specialties (ABMS) - ABMS member boards took over administration of the certifying examination in sleep medicine from ABSM in 2007. The ABMS site - www.abms.org - also has a credentials verification look-up function.
    c. ABMS member board sites. Each member board of ABMS that is involved in physician training in sleep medicine and administration of a specialty examination in sleep medicine has credentials verification. Those specific ABMS member sites are listed below:

American Board of Family Medicine
2228 Young Drive
Lexington, KY 40505-4294
Phone: 859-269-5626 or 888-995-5700
Fax: 859-335-7501 or 859-335-7509
Web site: **https://www.theabfm.org/cert/caq.aspx#caq4**

American Board of Internal Medicine
510 Walnut Street
Suite 1700
Philadelphia, PA 19106-3699
Phone: 215-446-3500 or 1-800-441-2246
Fax: 215-446-3633
Web site: **http://www.abim.org/certification/policies/imss/sleep.aspx**

American Board of Pediatrics
111 Silver Cedar Court
Chapel Hill, NC 27514
Phone: 919-929-0461
Fax: 919-929-9255
Web site: **http://www.abp.org**

American Board of Psychiatry and Neurology
500 Lake Cook Road, Suite 335
Deerfield, IL 60015
Phone: 847-945-7900
Fax:847-945-1146
Web site: **http://www.abpn.com/cert_subspecialties.htm**

American Board of Otolaryngology
5615 Kirby Drive
Suite 600
Houston, Texas 77005
Phone: 713-850-0399
Fax: 713-850-1104
Web site: **http://www.aboto.org**

Power Mobility Devices - Detailed Product Descriptions - Implications of Fee Schedule and Payment Policy Changes (MOB)

In order for a power mobility device (PMD) and related options and accessories to be covered, a detailed product description (DPD) signed and dated by the ordering physician must be obtained by the supplier prior to delivery. Two of the required elements of the DPD are the supplier's submitted charge and the Medicare fee schedule allowance. Medicare fee schedule allowances typically change with a new calendar year and may be revised at other times. If the supplier's submitted charge and fee schedule allowance are correct at the time that the DPD is signed by the physician but change prior to delivery of the PMD, the supplier is not required to obtain a new DPD. Also, if the DPD was completed in 2010 based on the submitted charge and fee schedule allowance for a purchased PMD, a new DPD is not required if the PMD is delivered in 2011 and billed as a rental. (Refer to *Power Mobility Devices LCD* for additional information relating to DPDs.)

Resubmitting Claims with Upgrade Modifiers (GEN)

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) issued bulletin articles regarding the use of upgrade modifiers in conjunction with HCPCS codes subject to the elimination of least costly alternative (LCA). For certain items that were previously subject to LCA, suppliers will now receive a not reasonable and necessary denial. The article indicated that further instructions would be forthcoming concerning the options that a supplier has if a claim for an item previously subject to LCA is submitted without upgrade modifiers, is subsequently denied as not reasonable and necessary and the supplier decides that it would like to utilize the upgrade modifiers.

For items that were previously subject to LCA, suppliers have the option of resubmitting the claim using the upgrade modifiers and the code for the covered medically necessary item rather than exercising the option of Appeals. For example, a supplier submits a claim after February 04, 2011 for code E0265 (fully electric hospital bed) and the claim is denied as not reasonable and necessary. That claim may be resubmitted with code E0265 and the appropriate modifiers on Line 1 and code E0260 and the appropriate modifiers on Line 2. Resubmitting the claim in this fashion will not result in a conflict with the original code E0265 claim and subsequent duplicate claim denial.

These resubmission instructions apply only to items previously subject to LCA payment policy that now receive not reasonable and necessary denials. Other items receiving reasonable and necessary denials must follow the usual redeterminations process.

For additional information on the use of upgrade modifiers, see the bulletin article entitled Use of Upgrade Modifiers published on the **NHIC, Corp. DME MAC A ListServe and web site on December 16, 2010.**

Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601) (GEN)

Historical Review Results
DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices (E0601), based on the results of a previous probe review. The previous probe findings covered the period from April 15, 2010 through June 20 2010 and resulted in a 39% Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (E0601). These findings cover claims with paid dates primarily from September 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 365 claims submitted by 213 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 86 (24%) of the claims. Of the 279 claims for which responses were received, 123 claims were allowed and 156 were denied resulting in a claim denial rate of 56%. 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 49.3%

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

- 65% of the denied claims did not have documentation verifying CPAP compliance either in a physician note or from a CPAP downloaded card.
- 58% of the denied claims did not have documentation of a physician re-evaluation assessing patient compliance and sleep improvement in a F2F visit.
- 42% of the denied claims did not have an initial F2F documenting the patient's need for a sleep study.
- 22% of the denied claims did not have a valid delivery ticket.

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

Example 1:

- Received - A DME order form. A sleep study form which provided enough medical necessity to replace the missing original Face to Face (F2F) by documenting somnolence, excessive fatigue, snoring, witnessed apnea, HTN, with an Apnea Hypopnea Index (AHI) of 14.3 events / hour and a diagnosis of Obstructive sleep Apnea (OSA). The study was digitally signed by a physician of the American Board of Sleep Medicine (ABSM). Physician attestation does not support medical necessity according to *Medicare Program Integrity Manual* (PIM), Chapter 5.7.
- Missing - An original (F2F) was not included. The Re-Evaluation F2F documentation was missing. No supportive documentation was received to verify that the patient is using and is compliant with the CPAP device. There was no valid delivery ticket. The beneficiary did not have any documentation demonstrating education and maintenance of the device.

Example 2:

- Received - Request for replacement for a CPAP device which was initially provided and covered while the beneficiary was in a Medicare fee-for-service. Received a physician's order. Received a supplier generated beneficiary check off statement (not needed). Original CPAP sleep study from 09/27/03 with AHI of 48.7 (not required). Received a CMN (not applicable for CPAP). Supplier created Advanced Beneficiary Notice of Noncoverage (ABN) is not an accepted form. The correct form is CMS-R-131 (03/08). (Please use only when the beneficiary legitimately may be declined by Medicare for payment, not for all beneficiaries.)
- Missing - Required for replacement is that if a PAP device is replaced following the 5 year reasonable useful lifetime, there must be a F2F evaluation by their treating physician that documents that the beneficiary continues to use and benefit from the PAP device. (There is no requirement for a new sleep test or trial period.) No valid delivery ticket.

Example 3:

- Received -Supplier generated beneficiary intake form (not necessary to process claim). Physician's prescription. Illegible page which appears to be insurance information of beneficiary (not necessary). An initial F2F demonstrating medical necessity by documenting snoring, daytime fatigue, witnessed apnea, HTN, and a neck circumference of 18". A diagnostic sleep study showing an AHI of 41.2. Beneficiary instructions and a valid delivery ticket. Patient received multiple follow up visits with physician, however each visit documented that the patient was non-compliant and did not wish to be compliant with the CPAP machine.
- Missing – Nothing
- Result - Claim denied due to non-compliance documented by the physician and per request of supplier.

Next Step
Based on the results of this prepayment review, DME MAC A will continue to review claims for Continuous Positive Airway Pressure Devices (E0601).

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 E0601 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:

- *Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528) LCD*
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- Previous articles on results of prepayment reviews: MR Bulletins
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_current.shtml
- *CERT Physician Letter - Positive Airway Pressure (PAP) Devices*
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_pap.pdf
- *CERT Documentation Checklist*
  http://www.medicarenhic.com/dme/articles/050109_certchecklist.pdf
- Monthly CERT Error examples
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faq_results.asp?categories=DME

Revised - Use of Upgrade Modifiers (GEN)

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it. When suppliers know that an item will not be paid in full because it does not meet the coverage criteria stated in the LCD, the supplier can still obtain partial payment at the time of initial determination if the claim is billed using one of the upgrade modifiers, GK or GL. The descriptions of the modifiers are:

GK - Reasonable and necessary item/service associated with a GA or GZ modifier

GL - Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

If a supplier wants to collect from the beneficiary for the upgraded item provided, a properly completed ABN must be obtained. If an ABN is obtained, on one claim line the supplier bills with a GA modifier the HCPCS code that describes the item that was provided. On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is covered based on the LCD. **(Note: The codes must be billed in this specific order on the claim.)** In this situation, the claim line with the GA modifier will be denied as not medically necessary with a "patient responsibility" (PR) message and the claim line with the GK modifier will continue through the usual claims processing. The beneficiary liability will be the sum of (a) the difference between the submitted charge for the GA claim line and the submitted charge for the GK claim line and (b) the deductible and co-insurance that relate to the allowed charge for the GK claim line. **The supplier may charge their "usual and customary" fee for the upgraded item that is provided.**

If a supplier wants to provide the upgraded item without any additional charge to the beneficiary, then no ABN is obtained. If it is the supplier's decision to provide the upgraded item at no additional charge to the beneficiary or if physician ordered the upgraded item and the supplier decides to provide it at no additional charge to the beneficiary, the supplier bills with a GL modifier the HCPCS code that describes the item that is covered based on the LCD. In this situation, the supplier does not bill the HCPCS code that describes the item that was provided.

If the request for the upgraded item is from the beneficiary and the supplier decides to provide it at no additional charge, no ABN is obtained. On one claim line the supplier bills with a GZ modifier the HCPCS code that describes the item that was provided. On the

next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is covered based on the LCD. **(Note: The codes must be billed in this specific order on the claim.)**

DME Upgrades - ABN and Claims Modifiers

	ABN Required	Required Modifier(s)	DMAC Payment	Beneficiary Pays for Upgrade
1) Physician orders upgrade:				
a) Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No
b) Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes
2) Patient requests upgrade:				
a) Supplier provides upgrade free of charge to beneficiary	No	GZ/GK	R&N item only (GK line)	No
b) Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes
3) Supplier provides upgrade for supplier convenience:				
a) Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No

Table Footnotes: GK or GL is added to HCPCS code for item that meets Medicare coverage requirements.
When GK is used, GA or GZ is added to HCPCS code for item that is provided.
R&N = Reasonable and necessary

Suppliers are reminded that if there is a requirement in a specific policy to use a KX modifier to indicate that an item meets coverage criteria, then it is used in addition to the GK or GL modifier. Codes with a GK or GL modifier will continue through the usual claims processing. Other edits may cause the GK/GL claim line to be denied. However, if no other edits are involved, payment will be made based on the fee schedule for the code with the GK or GL modifier.

Resubmitting Claims with Upgrade Modifiers

For certain items that were previously subject to least costly alternative (LCA) payment policy, suppliers will now receive a not reasonable and necessary denial. For these items only, suppliers have the option of resubmitting the claim using the upgrade modifiers and the code for the covered medically necessary item rather than exercising the option of Appeals. For example, a supplier submits a claim after February 4, 2011 for code E0265 (fully electric hospital bed) and the claim is denied as not reasonable and necessary. That claim may be resubmitted with code E0265 and the appropriate modifiers on Line 1 and code E0260 and the appropriate modifiers on Line 2. Resubmitting the claim in this fashion will not result in a conflict with the original code E0265 claim and subsequent duplicate claim denial.

These resubmission instructions apply only to items previously subject to LCA payment policy that now receive not reasonable and necessary denials. Other items receiving reasonable and necessary denials must follow the usual redeterminations process.

Specialty Enteral Formulas (PEN)

Effective with dates of service on or after February 04, 2011 claims submitted to the DME MAC's for HCPCS Codes B4149, B4153-B4157, B4161, and B4162 will no longer be subjected to least costly alternative payment policy and downcoded to B4150 or B4152 (semi-synthetic intact protein/protein isolate formulas). For dates of service on or after February 04, 2011, claims for HCPCS Codes B4149, B4153-B4157, B4161, and B4162 will be denied as not reasonable and necessary unless the coverage criteria for specialty nutrients is met. Suppliers also have the option of using the upgrade modifiers as noted in the recent DME MAC publication on *Use of Upgrade Modifiers*.

Refer to the *LCD for Enteral Nutrition* for additional coverage, coding and documentation requirements.

Urological Supplies - A4353 Correct Coding Clarification Policy Revision (SPE)

The Coding Guidelines section of the Urological Supplies Policy Article has been revised to clarify the correct coding for use of HCPCS code A4353 (Urinary intermittent catheter with insertion supplies). The revised passage states:

> A urinary intermittent catheter with insertion supplies (A4353) is a kit which includes a catheter and all supplies necessary for sterile insertion (see below). Code A4353 may be used if either 1 or 2 is supplied:
>
> 1. A sterile intermittent urinary catheter plus a separately packaged sterile kit of insertion/collection supplies; or,
> 2. A single sterile package containing both a catheter and all insertion/collection supplies.
>
> The insertion kit (A4353) contains a catheter (may be packaged separately from the other components), lubricant, gloves, antiseptic solution, applicators, a drape, and a collection tray/bag in a sterile package intended for single use. The collection tray/bag is a separate item included as part of the kit; therefore, materials that serve as non-sterile packaging to contain all of the items in the kit do not meet this requirement. Except as noted in 1 above, code A4353 must not be billed if individual insertion kit components are provided as separate items. When providing a sterile kit, the individual components must not be separately billed.

Suppliers are reminded that payment for code A4353 includes both the catheter and all insertion supplies. Separate billing for the catheter and/or any insertion supplies is incorrect.

The Local Coverage Determination (LCD) section on Intermittent Catheterization also has been revised to be consistent with the Coding Guideline above. The revised material in the LCD states:

> Refer to Coding Guidelines section of the related Policy Article for contents of the kit (A4353). A4353 should not be used for billing if the components are packaged separately rather than together as a kit. Separately provided components do not provide the equivalent degree of sterility achieved with an A4353. If separate components are provided instead of a kit (A4353) they will be denied as not reasonable and necessary.

Refer to the LCD, Policy Article, and *Supplier Manual* for additional information.

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/**

Are You Billing With Valid Ordering/Prescribing NPIs? CMS Editing Soon to Deny Claims (GEN)

Takeaway: *Avoid unnecessary denials. Confirm that all of your claims use the correct ordering/referring physician NPI.*

CMS Change Request 6421 (**http://www.cms.gov/transmittals/downloads/R823OTN.pdf**) was issued to remind providers that Section 1833(q)(1) of the *Social Security Act* has required since 1992 that a Medicare claim include the unique identification number for the ordering/referring physician. Per 6421 current implementation plans, the Centers for Medicare and Medicaid Services (CMS) is expanding the claim editing to meet the *Social Security Act* requirements for ordering and referring providers. **This means that claims containing NPIs which are not valid, including those from individuals without the authority to order DME, will be denied.**

Recent auditing of DME Jurisdiction A claims by the Office of Inspector General (OIG) confirms that this is an ongoing issue.

The following are the only providers who can order/refer beneficiary services under the Medicare program:

- doctor of medicine or osteopathy
- dental medicine
- dental surgery
- podiatric medicine
- optometry
- chiropractic medicine
- physician assistant
- certified clinical nurse specialist
- nurse practitioner
- clinical psychologist
- certified nurse midwife
- clinical social worker

The claim editing is being expanded to verify that the ordering/referring provider on a claim is eligible to order/refer and is enrolled in Medicare.

More information can be found in CMS *MLN Matters* article SE1011 here:
http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf

Ask-the-Contractor Teleconference (ACT) Q&A - December 21, 2010 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Tuesday, December 21, 2010 as a teleconference/webinar. A presentation of general updates and hot topics was provided followed by an open Q&A chat session.

Note: *Some questions may be rewritten to establish clarity. In addition, 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: **What is PECOS and how do I make sure we are compliant?**

A1: PECOS was established by the Centers for Medicare & Medicaid Services (CMS). It is the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and is an alternative to the paper (CMS-855) enrollment process. Internet-based PECOS will allow physicians, non-physician practitioners and provider and supplier organizations to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on status of a Medicare enrollment application via the Internet.

To learn more about PECOS and becoming compliant, access the following Web resources:

- CMS: Provider-Supplier Enrollment Web page (**http://www.cms.gov/MedicareProviderSupEnroll/**)
- DME MAC A: PECOS Web page (**http://www.medicarenhic.com/dme/dme_pecos.shtml**)

Q2: **What is the status of the PECOS deadline? Will it be extended?**

A2: The Centers for Medicare & Medicaid Services (CMS) previously announced that, beginning January 03, 2011, if certain Part B billed items and services require an ordering/referring provider and the ordering/referring provider is not in the claim, is not of a profession that is permitted to order/refer, or does not have an enrollment record in the Medicare Provider Enrollment, Chain and Ownership System (PECOS), the claim will not be paid. The automated edits were not turned on effective January 03, 2011 as initially anticipated. CMS has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). CMS will give providers ample advanced notice before claim rejections begin.

Q3: **When PECOS becomes effective, what are the provider's options for handling claims that reject due to a provider not being enrolled?**

A3: Claims that are rejected because they failed the ordering/referring provider edits are not denials of payment by Medicare; therefore, these claims can be resubmitted once the ordering/referring provider is enrolled in PECOS.

Q4: **Are your systems prepared for competitive bidding?**

A4: The DMEPOS Competitive Bidding Program files are updated on a quarterly basis in order to implement necessary changes to the HCPCS, Zip Code, Single Payment Amount and Supplier Files. Claims processing systems will be prepared for competitive bidding implementation as each applicable effective date is implemented. The competitive bidding items will be identified by HCPCS codes and the competitive bidding areas will be identified based on zip codes where beneficiaries receiving these items maintain their permanent residence. The DME MACs will have edits in place indicating which entities are eligible to bill for competitive bid items and the appropriate competitive bid payment amount.

Q5: **Are Medicare HMOs going to follow competitive bidding guidelines the same as traditional Medicare?**

A5: The Competitive Bidding Program applies to Original (Fee-for-Service) Medicare. All DMEPOS Competitive Bidding Program questions should be directed to the Competitive Bidding Implementation Contractor (CBIC).

Q6: **What does grandfathering mean when speaking about the competitive bidding program?**

A6: All non-contract suppliers that furnish competitively bid rented durable medical equipment (DME) or oxygen and oxygen equipment to beneficiaries in CBAs must decide if they will elect to become grandfathered suppliers, notify beneficiaries of their grandfathering decisions, and fulfill other requirements. For Round 1, non-contract suppliers that wanted to elect to become a grandfathered supplier had to provide written notification to the Centers for Medicare & Medicaid Services (CMS) of this decision by Wed Nov 17, 2010.

All DMEPOS Competitive Bidding Program questions should be directed to the Competitive Bidding Implementation Contractor (CBIC).

Q7: **When will competitive bidding come to the Boston area?**

A7: At this time, there is no information on Boston implementation. The current list of Competitive Bidding Areas (CBAs) is available on the CMS Web site and the CBIC Web site. All DMEPOS Competitive Bidding Program questions should be directed to the Competitive Bidding Implementation Contractor (CBIC).

Q8: **Will there be a list of providers that were awarded contracts for competitive bidding?**

A8: Yes, the list is available on the Competitive Bidding Implementation Contractor (CBIC) Web site at **http://www.dmecompetitivebid.com**. All DMEPOS Competitive Bidding Program questions should be directed to the Competitive Bidding Implementation Contractor (CBIC).

Q9: **If a Medicare beneficiary is a snowbird and has an address in a competitive bidding area (CBA) how do we get paid for supplying our equipment?**

A9: Beneficiaries who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. This includes beneficiaries who do not live in a CBA but who obtain competitively bid items while traveling to a CBA.

Two important competitive bidding program rules to know when a beneficiary travels are:

1. Payment is always based on the beneficiary's permanent residence*.
   Does the beneficiary permanently reside within a CBA or outside a CBA?

2. The supplier that may provide the item depends upon whether the item is included in the competitive bidding program and where the beneficiary obtains the item.
   Is the item a competitively bid item?
   Is the item being obtained inside or outside a CBA?

* The permanent residence is the address on file with the Social Security Administration. It is the address to which the beneficiary's Social Security checks are mailed.

For additional information, refer to the DMEPOS Competitive Bidding Program Traveling Beneficiary Fact Sheet (**http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp**) available on the CMS Web site.

All DMEPOS Competitive Bidding Program questions should be directed to the Competitive Bidding Implementation Contractor (CBIC).

Q10: Can I check the web and/or the IVR to see if a patient is receiving Home Health care?
A10: The following Home Health details are currently available in the DME MAC A IVR:

- Home health name
- Address
- Admission/discharge dates
- Status of the beneficiary

Q11: Do we need to collect patient testing logs for each refill of diabetic supplies and are we required to have this in our possession at all times?
A11: No. Patient testing logs do not need to be collected for each refill and are only required on a regular basis (ever 6 months) when the physician has ordered an amount of supplies that exceed the utilization guidelines set forth in the LCD. The point at which you chose to collect this information is a business decision; however, it is recommended that you have the necessary documentation on hand sooner rather than later in the event that an audit.

Q12: Will the HCPCS code L3670 (shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, including fitting and adjustment) be a discontinued code effective 12/31/2010?
A12: No. CMS released a modification to the Healthcare Common Procedure Coding System (HCPCS) code set. Code L3670 has been reinstated. This change has been posted to the 2011 HCPCS Corrections document located on the CMS HCPCS Web page (**http://www.cms.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp**).

Q13: If a patient qualifies for an L1820 (knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment) but requests a L1831 (knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment) how do we handle the difference in the price?
A13: If a supplier wants to collect from the beneficiary for the upgraded item provided, a properly completed ABN must be obtained. If an ABN is obtained, on one claim line the supplier must bill with a GA modifier for the HCPCS code that describes the item that was provided. On the next claim line, the supplier must bill with a GK modifier for the HCPCS code that describes the item that is covered based on the LCD.

Q14: What modifiers must be used for a monthly capped rental of an E0601?
A14: All capped rental items are required to be billed with the RR modifier and the following capped rental related modifiers:

- KH - 1st month claim of capped rental
- KI - 2nd and 3rd month claims for capped rental
- KJ - 4th through 13th month claims for capped rental

In addition to the above mentioned modifiers, additional modifiers may apply according to policy provisions. Refer to the specific Local Coverage Determination (LCD) for the particular item in question in order to determine if additional modifiers are necessary.

Q15: What is included in code A4222?
A15: Code A4222 includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges, and preparation charges. This code is not used for a syringe-type reservoir.

Q16: **When billing for an A7034 (nasal application device) is a new order required each time a patient gets a new one.**
A16: A new order is required in the following situations:

- There is a change in the order for the accessory, supply, drug, etc.
- On a regular basis (even if there is no change in the order) only if it is so specified in the Documentation section of a particular medical policy
- When an item is replaced
- When there is a change in the supplier
- In cases where two or more suppliers merge, the resultant supplier should make all reasonable attempts to secure copies of all active CMNs from the supplier(s) purchased. This document should be kept on file by the resultant supplier for future presentation to the DME MAC.

Q17: **How do we bill for maintenance/service for power wheelchairs?**
A17: Maintenance and service is no longer billable for capped rental items in which the first rental month occurred on or after January 01, 2006.

Q18: **Where do we get the cover sheet we are supposed to use to fax information for the PWK segment?**

A18: 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. Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.

Q19: **How do we find all the fee schedules?**
A19: The DMEPOS fee schedules are accessible from one central location of the DME MAC A Web site. To easily access the fee schedules, refer to the DME MAC A Home Page and select "Fee Schedules" from the "Quick Links" section located on the upper right side of the page.

Q20: **Will Medicare still reduce claim payment by 10% under the new timely filing requirements or will they deny the untimely claims outright?**
A20: Previously, the 10% reduction only applied to assigned claims submitted more than 12 months after the service date. Since the maximum period for submission is now reduced to no more than 12 months this previous rule will no longer apply.

Claims with dates of service on or after January 01, 2010, must be received by your Medicare contractor no later than one calendar year (12 months) from the claim's date of service - or Medicare will deny the claim.

Q21: **Will there be changes to the redetermination forms for providers with more than one NPI number?**
A21: When submitting a redetermination request to the DME MAC, only one NPI is needed on the Redetermination Form. This would be the NPI that is related to the item/service you are appealing. For example, if you are a podiatrist that has two NPIs (one for physician related services and one for DMEPOS related services) you would use the NPI associated with the DMEPOS billing privileges.

Q22: **Does Option #1 on ABN form allow the provider to obtain payment from the beneficiary up front?**
A22: Yes. Option #1 allows the beneficiary to receive the items and/or services at issue and permits the provider to request payment up front. Option #1 requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed.

Q23: **Who can be an "authorized representative" for an ABN signature?**
A23: An authorized representative is an individual who may make health care and financial decisions on a beneficiary's behalf (e.g. the beneficiary's legal guardian or someone appointed according to a properly executed "durable medical power of attorney").

Billing for Denial of Items Previously Listed in the Home Dialysis Equipment and Supplies LCD for Non-ESRD Beneficiaries (SPE)

DME MAC A has received an increase in inquiries on the proper billing for denial of DME and supplies that were included in the retired *Home Dialysis Equipment and Supplies LCD*. Refer to the "*Home Dialysis and Epoetin - Medical Policies Retired*" Bulletin (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/122310_epo.pdf**) for additional details on the LCD retirement.

Many of the items included in the retired Home Dialysis LCD may also be used for beneficiaries whom are not on ESRD. (i.e. blood pressure monitors, sterile gloves, alcohol wipes, etc.) For Non-ESRD beneficiaries, these items are statutorily excluded. Therefore, in order to obtain a denial for a secondary insurer, these items and supplies must be billed with a GY modifier appended. The narrative field should also include an explanation of the reason for the GY modifier usage. (i.e. "Item is Non-Covered for Non-ESRD Beneficiary") This should produce a non-covered denial as opposed to an incorrect contractor denial.

The GY modifier should not be used for dialysis supplies provided to a beneficiary with ESRD. Those claims must be submitted to the A/B MAC Contractor.

Billing Reminder - Wheelchair Options/Accessories - Use of RT and LT Modifiers (MOB)

Per the Wheelchair Options/Accessories Policy Article, the right (RT) and left (LT) modifiers must be used when appropriate.

It is important to understand that different billing rules apply depending on whether the unit of service for the HCPCS code is described as "each" or "pair" and also whether the item is billed as a "purchase" or "rental".

The following billing rules apply to situations when two of the same bilateral items in the *Wheelchair Options and Accessories LCD* are dispensed on the same date of service for both the left (LT) and right (RT) side:

Bilateral Items Billed as "Purchase" - Unit of Service is "Each" (See Billing Example #1)
If bilateral items are provided as a "purchase" and the unit of service described in the HCPCS code description is "each", bill both items on the same claim line using the LTRT modifiers and 2 units of service.

Bilateral Items Billed as "Rental" - Unit of Service is "Each" (See Billing Example #1)
If bilateral items are provided as a "rental" and the unit of service described in the HCPCS code description is "each", bill the items on two separate claim lines with the LT modifier on one line and the RT modifier on the other. Each claim line will have 1 unit of service. Note exception in billing example below.

Bilateral Items Billed as "Purchase or Rental" - Unit of Service is "Pair" (See Billing Example #2)
If bilateral items are provided as a "purchase or rental" and the unit of service described in the HCPCS code description is "pair", bill both items on the same claim line with 1 unit of service. The LT and RT modifiers are not reported when the unit of service is "pair".

The following billing rules apply to situations when a single item in the *Wheelchair Options and Accessories LCD* is dispensed for either the left (LT) or the right (RT) side, but not both:

Single Item Billed as "Purchase or Rental" - Unit of Service is "Each" (See Billing Example #3)
If a single item is provided as a "purchase or rental" for either the left (LT) or right (RT) side bill one claim line using the appropriate modifier LT or RT and 1 unit of service. This only applies to HCPCS codes that have a unit of service description of "each". Note exception in billing example below.

Billing Example #1 - Bilateral Items Dispensed as "Each":
The following table represents billing examples for situations when two of the same bilateral items in the *Wheelchair Options and Accessories LCD* are dispensed on the same date of service for both the left (LT) and right (RT) side and are billed with a HCPCS code that has a unit of service described as "each". The table includes examples for both purchase and rental situations.

Exception: The HCPCS code description for E1020 does not indicate a unit of service of "each" or "pair"; however, it is an item that can be dispensed individually for one side or for both the left (LT) and right (RT) side. As a result, billing instructions are based on "each".

Note: The examples in the following table are not all inclusive of all modifiers. Additional modifiers may be required to address whether coverage criteria are or are not met (KX, GA, GY, GZ). Claim lines billed without all required modifiers will be rejected for missing information.

HCPCS Code	Rental/Purchase	# of Claim Lines	LT/RT Modifier Use	Unit of Service
E0990 (each)	Purchase	1	E0990 NU LT RT	2
	Rental	2	E0990 RR LT E0990 RR RT	1 1
E1020	Purchase	1	E1020 NU LT RT	2
	Rental	2	E1020 RR LT E1020 RR RT	1 1

Billing Example #2 - Bilateral Items Dispensed as "Pair"
The following table represents billing examples of situations when two of the same bilateral items in the *Wheelchair Options and Accessories LCD* are dispensed on the same date of service for both the left and right side that are billed with the same HCPCS code that describes the unit of service as "pair". The table includes separate billing examples for rental and purchase situations, if applicable. Currently, the *Wheelchair Options/Accessories LCD* includes three HCPCS codes, identified in the table below, that are dispensed as a "pair".

Note: The examples in the following table are not all inclusive of all modifiers. Additional modifiers may be required for capped rental items (KH, KI, KJ) and to address whether coverage criteria are or are not met (KX, GA, GY, GZ). Claim lines billed without all required modifiers will be rejected for missing information.

HCPCS Code	Rental/Purchase	# of Claim Lines	LT/RT Modifier Not Applicable	Unit of Service
K0195 (pair)	Rental only	1	K0195RR	1
K0020 (pair)	Purchase	1	K0020 NU	1
	Rental	1	K0020 RR	1
E1010 (pair)	Purchase	1	E1010 NU	1
	Rental	1	E1010 RR	1

Billing Example #3 - Single Item Dispensed as "Each":
The following table represents billing examples of situations when a single item from the *Wheelchair Options and Accessories LCD* is dispensed as a "rental or purchase" for either the left (LT) or right (RT) side with a HCPCS code that describes the unit of service as "each".

Exception: The HCPCS code description for E1020 does not indicate a unit of service of "each" or "pair"; however, it is an item that can be dispensed individually for one side or for both the left (LT) and right (RT) side. As a result, billing instructions are based on "each".

Note: The examples in the following table are not all inclusive of all modifiers. Additional modifiers may be required to address whether coverage criteria are or are not met (KX, GA, GY, GZ). Claim lines billed without all required modifiers will be rejected for missing information.

HCPCS Code	Rental/Purchase	# of Claim Lines	LT/RT Modifier Use	Unit of Service
E0990 (each)	Purchase	1	E0990 NU LT or E0990 NU RT	1
	Rental	1	E0990 RR LT or E0990 RR RT	1
E1020	Purchase	1	E1020 NU LT or E1020 NU RT	1
	Rental	1	E1020 RR LT or E1020 RR RT	1

Fourth Quarter 2010 - Top Claim Submission Errors (GEN)

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

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 - Invalid Procedure Code and/or Modifier	218,905	The procedure code, modifier, or procedure code and modifier combination is invalid.
C095 - Diagnosis Code Invalid - Pointer 1	49,165	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
C044 - Subscriber Primary ID Invalid	41,987	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C171 - Capped Rental - Modifier Missing	36,525	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)	35,195	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	31,321	There is no link between the NPI that was submitted and a PTAN/NSC.
A202 - Date of Service > Create Date	28,681	The "from" date of service or the range of dates of service is a future date

Top Ten Claims Submission Errors	Number Received	Reason For Error
B108 - Billing provider not authorized for submitter	24,913	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C143 - Ordering Provider ID Qualifier Invalid	21,303	The Ordering Provider NPI was not sent or the Ordering Provider's UPIN was sent on a charge line.
C179 - – Service From/To Dates Not Equal	20,402	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.

Fourth Quarter 2010 – 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 fourth quarter of 2010. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

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

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form(or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	33,668
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.	11,284
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.	5,462
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).	2,218
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.	1,786
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.	1,277
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).	1,061
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.	826
CO 16 N286 Missing/incomplete/invalid referring provider primary identifier.	**Item 17A** - Physician UPIN (Unique Physician Identifier Number) submitted in error. Physician NPI must be submitted in Item 17B.	778
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.	585

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

Medicare Electronic Funds Transfer (EFT) Reminders (GEN)

NHIC, Corp. DME MAC A would like to remind suppliers of the Electronic Funds Transfers (EFT) enrollment requirement. EFT allows Medicare payments to be received electronically by the provider of Medicare services rather than paper checks delivered by mail, and it is the required method of Medicare payment for all providers entering the Medicare program for the first time. It is also required for existing providers that are submitting a change to their existing enrollment data and are not currently receiving payments via EFT.

EFT Benefits

- Faster access to funds (many banks credit direct deposits faster than paper checks)
- Elimination of the risk of Medicare paper checks being lost or stolen in the mail
- Reduction of the amount of paper in the office
- Valuable time savings for staff and avoidance of hassle associated with going to the bank to deposit Medicare checks
- Easier reconciliation of payments with bank statements

How to Enroll in EFT

To enroll in EFT first complete the *Electronic Funds Transfer (EFT) Authorization Agreement* (FORM CMS-588) and mail it with an **original, voided check pre-printed with your company name to**:

NHIC, Corp.
EFT DME ENROLLMENTS
PO Box 9185
Hingham, MA 02043-9185

Download and view the *CMS-588 Checklist* to make sure you haven't missed any important information in your application. **Note that bank deposit slips, photocopies of checks and hand-written names or addresses on checks are not accepted.**

EFT enrollments typically take 30 days to process (which includes a 15 day pre-note test period). Applications that are filled out incorrectly or have missing data will take longer to process.

As original checks and signatures are required, we cannot accept your EFT application via fax.

Changing your EFT banking details?

If you currently receive payments via EFT and need to make changes to your banking details, you will need to follow the same procedures for completing a new application. For your protection, the DME EFT support staff will call you to confirm changes to your EFT details before they are processed in the system.

EFT FAQ

Question: Am I required to enroll in EFT?
Answer: As stated in 42 CFR §424.510(d) (2) (IV) and §424.510(e), all providers (including Federal, State and local governments) entering the Medicare program for the first time must use EFT in order to receive payments. Any provider not currently on EFT that: (1) submits any change to existing enrollment data or (2) submits a revalidation application, must also submit a CMS-588 form and thereafter receive payments via EFT.

Question: Can I un-enroll from EFT?
Answer: Once a provider begins to receive Medicare payments via EFT, the contractor shall not issue any routine, ongoing payments to the provider via check. (For purposes of this instruction, the term "routine, ongoing payments" means those payments that are not considered to be "special payments," as that latter term is used in section 4 of the CMS-855

application.) This means that, with the exception of special payments, a provider that receives payments via EFT must continue to receive payments via EFT and cannot switch back to receiving paper checks, even in cases of a MAC transition or other CMS-initiated action. Medicare contractors shall not approve any requests to change the provider's payment method from EFT to check. (Reference: *Medicare Claims Processing Manual*, Chapter 24)

Question: How long will it take to process my EFT application?
Answer: Generally, you can expect to see payments in your bank within 30 days of NHIC receiving your EFT application (this includes a 15-day pre-note test period). Incomplete or inaccurate information on your application can delay processing time.

Question: Will I be notified when my EFT is processed?
Answer: Yes, you will receive a letter in the mail stating that your EFT has successfully been processed and an approximate time of when you can begin to expect direct payments into your bank account.

Question: I received an "Additional Information Request" letter, now what?
Answer: Your EFT application can be rejected for a number of reasons, most commonly for incomplete or inaccurate information, the form not signed by the authorized or delegated official on record with Medicare or not enclosing the proper banking documentation. See the *CMS-588 Checklist* for a guideline on filling out your application. Please supply the information requested and a copy of the letter you received and mail it in for processing.

Question: Where do I send my EFT documentation?
Answer: As original checks and signatures are required, we cannot accept your EFT application via fax. Please submit by regular mail to:

NHIC, Corp.
EFT DME ENROLLMENTS
PO Box 9185
Hingham, MA 02043-9185

Question: How will I receive my checks until EFT is active?
Answer: You will receive paper checks until the EFT process is complete

EFT Resources

- *Electronic Funds Transfer (EFT) Authorization Agreement* (FORM CMS-588) (**http://cms.gov/cmsforms/downloads/CMS588.pdf**)
- *CMS-588 Checklist* (**http://www.medicarenhic.com/dme/edi/EFT_CMS-588_Checklist.pdf**)
- Join NHIC, Corp ListServe (**http://www.medicarenhic.com/dme/listserve.html**)

EFT Support
Contact our DME EFT Support Staff at 866-563-0049 from 8:00 a.m. to 4:00 p.m. EST, Monday through Friday.

NHIC, Corp. DME MAC Web site Search Tips (GEN)

Medicare NHIC, Corp. utilizes the power of Google to provide you with an easier and faster way of accessing information on our web site. This article provides tips on how to create queries that would produce the best search results.

The Basics
A query is simply a description of information that you need. The Search tool will search for documents that are a best match for the words in your query. It will also search for documents that are about the same concepts that your query describes. Sometimes the search will bring back articles that don't mention any of the words in your original query.

Don't worry about providing too many words - **the more words, the better**. Additional words will help the Search figure out what concepts you're really interested in. On the other hand, the Search will do a pretty good job of figuring out what documents are interesting to you even if your query is unclear.

For example, let's say you're searching a Web site for documents about a manual wheelchair. You would type in:
Manual Wheelchair

If you have a particular question about manual wheelchair accessories, for example: when legrests are covered, you would type in:
Manual Wheelchair Accessories Legrests

Even if there are no documents that are actually about coverage of manual wheelchair legrests, the Search will still show you documents on manual wheelchair accessories.

Search Query Tips
Our search tool offers numerous options for making your searches more precise and useful. You could easily improve your search results by adding operators (+, -, or) to your search terms or by using our advanced search tool.

Here are some suggestions for getting the best search results:

Use More Words
The easiest way to narrow your search and the first thing you should try is to use more words. The greater the detail you provide, the better search is able to find precisely what you're looking for.

Use "+" to require words
If a word is essential to getting the results you want, or if you want to ensure a word is included exactly as you enter it, add a " + " sign immediately in front of it.

Example Search: **Glucose Monitors +LCA**, this ensures that results will include "LCA" in a search for "Glucose Monitors +LCA".

Use "-" to exclude words
If you put a minus sign " - " in front of a search word, the search will make sure that NONE of the documents it returns contain the word. Do not put any space between the minus sign " - " and the word.

Example: If you are looking for documents regarding orthopedic footwear but not therapeutic shoes.
Search: **Footwear -Therapeutic**; None of the results will have the word "Therapeutic" in them.

Synonym Search
If you want to search not only for your search term but also for its synonyms, place the tilde sign " ~ " immediately in front of your search term.

Example Search: **~Doctor**. This search would return results that include "medical", "physician" and "doctor".

You can use the AND, OR, NOT, and AND NOT, and quotation marks ""
What they do/How to use them:

AND - Documents found must contain all words joined by the word AND. Note that this is equivalent to putting a plus sign " + " in front of the word.

Example Search: To find documents that have all of the words hospital bed, upgrade, and ABN, you could enter: **hospital bed AND upgrade AND ABN**

OR - Documents found must contain at least one of the words joined by OR.

Example Search: To find documents that have either the words upgrade or ABN you could enter: **upgrade OR ABN**

" " - Quotation marks are used to search an exact phrase.

Example Search: **"1500 Claim Form"**. All results return with the exact phrase 1500 Claim Form.

Operator	Definition	Example
" " Quotes	To find documents that contain that exact phrase.	"1500 form"
OR	To find documents with at least one of the words.	wheelchairs OR walkers
AND	Documents found must contain all words joined by the word AND	hospital bed AND upgrade AND ABN
- Hyphen	Documents that don't have a particular word.	footwear -therapeutic
Specific Date	Find items that include a specific date	wheelchairs(2011)
+ Sign	To ensure a word is included exactly as you enter it	Wheelchairs +accessories

Advanced Search
The advanced search page gives you the power to specify search keywords exactly how you want them. You can do a lot more with search than just typing in keywords. With Advanced Search, you can search for pages that fall under the following criteria:

- Contains ALL the search terms you type in
- Contains the exact phrase you type in
- Contains at least one of the words you type in
- Does NOT contain any of the words you type in
- Documents in a certain file format
- Documents that have been updated within a certain period of time
- Documents within a certain site (Part B, DME or Beneficiaries)

Immediate Offset Requests – Reminder (GEN)

All immediate offset requests should be faxed to the Overpayments department at 781-741-3916. Remember that effectuating an immediate offset requires both the request and sufficient claim payments due to that provider. In addition, established debts automatically go into offset 40 days after the demand letter date; submitting an immediate offset request after 40 days have passed is unnecessary.

Requests for immediate offset on established debts: *You have received a demand letter* - Requests received through our fax line are processed by the next business day. The most common reason that a requested offset has not been taken is that there have not been sufficient claims payments for that supplier. Also, interest accrues on established debts after 30 days from the demand letter date. To avoid interest charges, immediate offset requests should be sent as soon as possible after receipt of the demand letter. It is not necessary to fax the entire demand letter with an offset request - *if the demand letter is from NHIC, only the first page is needed; if the demand letter is from DCS (the RAC) only the last page (the spreadsheet) is needed.*

Requests for immediate offset with a supplier identified overpayment: The process for these requests is different than for other immediate offset requests; these are processed within 45 days. **Please consider this time period before re-faxing the same request.** The system will automatically generate a demand letter on these voluntary overpayments even though an immediate offset was already set up. It is not necessary to send a new request for immediate offset when you receive that demand letter.

Suppliers can track the status of their adjustments and offsets on their remittance advice or through option 5 of the Interactive Voice Response (IVR) system at 866-419-9458.

Reminder from the Reopening and Written Inquiries Departments (GEN)

A reminder from the Reopening and Written Inquiries Departments for timely and efficient processing of your requests:

- Reopenings cannot be completed on unprocessable claims. These claims must be resubmitted. Please see the reminder on unprocessable claims at: **http://www.medicarenhic.com/dme/articles/112009_resub.pdf**
- Reopenings cannot be completed on claims that involve overpayments/recoupments. These claims must be processed through appeals. Please use the Medicare Redetermination Request form located on our web site at: **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms**

  * Be sure to select the appropriate Overpayment Appeal "check- off" box.

Please be sure to file your requests as indicated above to streamline your correspondence process and avoid unnecessary processing delays.

Reimbursement Reminder from the Redetermination Department (DRU)

The Redetermination Department wants to advise the supplier community of the following information to avoid unnecessary denials and appeals:

- The base equipment must be billed prior to or in conjunction with the associated drugs, dispensing fees, or supplies in order for these items to be considered for payment
- If billing drugs and/or supplies, the supplier should indicate the specific time frame in which these items are being used. i.e., 30 day supply, 60 day supply, 90 day supply, etc. This information can be entered in the NTE 2300 or 2400 field for electronic claims or Item 19 for paper claims

Please be sure you are filing your claims with the above information to streamline your claims process and avoid these unnecessary denials.

Reopening and Redetermination Form Updates (GEN)

DME MAC Reopening Request Form, Checklist, and Completion Guide
A new universal *Reopening Request Form* for all DMEPOS suppliers to use when submitting a reopening request either by mail or fax is now available. The new form is designed so that you can easily include all of the basic information needed to submit a reopening request to any of the four **DME MAC Jurisdictions**. This means that suppliers who submit claims across multiple jurisdictions will only need to complete this one *Reopening Request Form* regardless of which DME MAC to whom they are submitting their request. Representatives from all four DME MACs collaborated to create the new form in order to ensure consistency in reopening requests across all jurisdictions. Using the new form will help to streamline the reopening submission process and will help the DME MACs to ensure that your request is processed timely and accurately.

The four DME MACs have also developed a *Reopening Request Form Checklist* and *Reopening Request Form Completion Guide*. Suppliers are encouraged to use these tools to determine:

- If a claim can be reopened;
- If a reopening is the appropriate step to take in order to resolve their initial claim determination issue(s); and
- How to properly complete the DME MAC Reopening Request Form.

The *DME MAC Reopening Request Form*, *Reopening Request Form Checklist*, and *Reopening Request Form Completion Guide* are located at: **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms**

Revised Medicare DME Redetermination Request Form and Completion Guide
The *Medicare DME Redetermination Request Form* has been revised to include a checkbox for suppliers to indicate the jurisdiction they are submitting the request for redetermination. Furthermore, in an effort to assist suppliers who submit requests for redeterminations via fax, the fax number for each jurisdiction has been added. The *Medicare DME Redetermination Request Form Completion Guide* has also been revised to include instructions regarding these changes. The revised form is valid in all four DME MAC Jurisdictions. This means that suppliers who submit claims across multiple jurisdictions will only need to complete this one *Redetermination Request Form* regardless of which DME MAC to whom they are submitting their request.

The revised form and completion guide are now available at: **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms**

Jurisdiction A DME MAC IVR Enhancements Effective January 14, 2011 (GEN)

To better serve our DME MAC A supplier community, effective Friday, January 14, 2011, the Interactive Voice Response (IVR) system was enhanced to offer additional information.

Claims (option 1)
Suppliers now have the option to obtain outstanding payment information. When a supplier selects the Claims option, the supplier will be required to enter their National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5 digits of the Tax Identification Number (TIN). Once the authentication elements have been verified, suppliers are able to obtain beneficiary claim information (touch-tone 1) or outstanding payment information (touch-tone 2). The outstanding payment information provides:

- The total number of pending claims and the total submitted amount for those claims.
- The total number of claims pending the payment floor and the total submitted amount of those claims.

Beneficiary claim information (option 1, touch-tone 1) was enhanced with the following:

- If a claim submitted to the Jurisdiction A DME MAC was incomplete, the IVR will advise, “check the appropriate submitted information and resubmit their claim”.
- If a claim submitted to the Jurisdiction A DME MAC was denied due to Skilled Nursing, Inpatient Stay, Home Health, or Hospice, suppliers are able to obtain the admission/discharge dates and the beneficiary status. The supplier will also be provided with the name and the address of the facility. Suppliers will need to say claim details (touch-tone 4) to obtain this information.
- Claims denying for Skilled Nursing Facility with a patient status of “30”. If the beneficiary status is “30”, the IVR will read the admit date, and advise the beneficiary is still inpatient status. The IVR will not read the NPI number of the facility.

Suppliers are reminded that the following information can currently be obtained through the IVR.

Eligibility (option 2)
Suppliers are able to obtain Home Health episode information for the beneficiary. The supplier is able to obtain the admission/discharge dates and the status of the beneficiary. The supplier will also be provided with the name and the address of the facility.

PECOS Enrollment (option 8)
Suppliers are able to verify if the ordering physician is enrolled into the Medicare Provider Enrollment, Chain and Ownership System (PECOS). By selecting option 8 from the main menu, suppliers will be required to enter the NPI of the ordering physician. You will be prompted to say the full name of the ordering physician, or spell the name. If the ordering physician is enrolled, you will hear “this provider is enrolled in the Medicare program”.

If the ordering physician NPI submitted does not match the NPI, the IVR will voice back “The NPI entered is not valid to refer Medicare services”.

If the ordering physician’s first and last name submitted does not match the first and last name, the IVR will voice back “The name provided does not match the NPI”.

Please call **866-419-9458** to utilize these new enhancements. The IVR is available:

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

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

Eligibility Options Available via the Jurisdiction A DME MAC IVR (GEN)

The DME MAC A Call Center has seen an increase of calls due to eligibility denials for a Medicare beneficiary. Some of the common ANSI denials associated with eligibility include, but aren't limited to:

- **ANSI 22:** Payment adjusted because this care may be covered by another payer per coordination of benefits.
- **ANSI 13:** The date of death precedes the date of service.
- **ANSI 24:** Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
- **ANSI B15 with remark code N70:** This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Consolidated billing and payment applies.
- **ANSI 45 with remark code N88:** Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. This payment is being made conditionally. A Home Health Agency episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
- **ANSI B9:** Patient is enrolled in a Hospice
- **ANSI 109 with remark code M2:** Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. Not paid separately when the patient is an inpatient.
- **ANSI 109 with remark code MA101:** Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.

Note: *The ANSI denials listed above typically have a CO (contractual obligation) or PR (patient responsibility) reported with the code.*

The Centers for Medicare & Medicaid Services (CMS) requires suppliers to utilize self-service options, such as the interactive voice response (IVR) system. When calling the DME MAC A Call Center and asking for eligibility and/or explanation of a denial, you will be directed back to the IVR.

The IVR, **866-419-9458**, is available for the supplier community Monday -Friday, 6:00 a.m. - 7:00 p.m. EST and Saturday, 6:00 a.m. - 3:00 p.m. EST

In order to obtain eligibility through the IVR, suppliers will need to select option 2. After selecting option 2, the IVR will request and collect the following elements:

- NPI
- PTAN (ten-digit supplier number)
- Last five digits of the Tax Identification Number (TIN)
- Beneficiary Medicare number
- Beneficiary first and last name (last name and first initial if using touch-tone)
- Beneficiary date of birth
- Date of service

Once the authentication elements have been verified, the IVR will supply the following information:

- Part A and Part B effective/termination dates
- Current/prior year Part B deductible amounts

- Medicare secondary payer (MSP) type, insurer name, and effective/termination dates
- Medicare advantage plan number, name, address, telephone number, and effective/termination dates
- Home health name, address, and effective/termination dates
- Hospice name, address, and effective/termination dates
- Date of death
- Corrected Medicare number

Effective January 14, 2011, a new enhancement was added to the Claims option (option 1) on the IVR. Suppliers are able to select Claim Details (touch tone 4) in order to obtain admission/discharge dates and patient status date if the claim denied due to Home Health, Hospice, Inpatient Stay, or Skilled Nursing Facility. Suppliers will also be able to obtain the name and address of the facility.

For additional information on the IVR or the Provider Contact Center visit **http://www.medicarenhic.com/dme**, select 'Contact Information' from the left hand navigation menu and choose Customer Service.

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 December of 2010 chapters 1, 3, 8, 9 and 10 of the *DME MAC A Supplier Manual* were updated. Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones.

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/**

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

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

March 2011
Number 19

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

NHIC, Corp.
A CMS Contractor

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