DME MAC Jurisdiction A Resource

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

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Billing Finance

General Information

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

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Legend

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

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

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
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Note: *This article was revised on July 25, 2011 to provide important new information regarding the KY modifier on page 4. 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. (**However,**

effective October 1, 2011, the KY modifier is not required on these claims. Any claims submitted after September 30, 2011 with the KY modifier will be denied. For more details, see article MM7389 at http://www.cms.gov/MLNMattersArticles/downloads/MM7389.pdf on the CMS website.) The following HCPCS codes are the codes for which use of the KY modifier is authorized for dates of service of January 1-September 30, 2011:

- 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/SPA** 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.

Following 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.

Claim Status Category Code and Claim Status Code Update (MM7456) (GEN)

MLN Matters® Number: MM7456
Related CR Release Date: June 17, 2011
Related CR Transmittal #: R2243CP
Related Change Request (CR) #: 7456
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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

Provider Action Needed
This article, based on CR7456, 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 and the Health Care Claim Acknowledgement ASC X12N 277 that are updated during the October 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting will be posted at **http://www.wpc-edi.com/content/view/180/223/** on or about November 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 October 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

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

Additional Information
The official instruction, CR7456 issued to your FI, A/B MAC, and DME MAC regarding this change may be viewed at **http://www.cms.gov/transmittals/downloads/R2243CP.pdf** on the CMS website.

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

Edit to Deny Claims for Repairs to Capped Rental Durable Medical Equipment (DME) (MM7212) (GEN)

MLN Matters® Number: MM7212 Revised
Related CR Release Date: May 13, 2011
Related CR Transmittal #: R901OTN

Related Change Request (CR) 7212
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Note: *This article was revised on June 21, 2011, to correct the messages (page 2) used when a claim is denied. All other information is unchanged.*

Provider Types Affected
This article is for suppliers and providers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for rentals of capped Durable Medical Equipment (DME).

Provider Action Needed
Change Request (CR) 7212 instructs Medicare DME MACs to prohibit separate payment for repairs to capped rental items during the rental period. The rental period is not to exceed 13 continuous months. However, payment for all maintenance, servicing, and repair of capped rental equipment is included in the allowed rental payments. Under no circumstances will Medicare pay for these services prior to the end of the 13-month capped rental period. Suppliers of capped rental items need to be aware of this issue as it impacts maintenance and servicing of DME for Medicare beneficiaries as described in this article.

Key Points of CR7212
- Claims for replacement parts for capped rental items billed during the 13-month capped rental period with the "RB" modifier, including parts submitted using code E1399, will be denied.
- Claims for repairs that are billed with the Healthcare Common Procedure Coding System (HCPCS) code K0739 for the labor associated with repairs of capped rental equipment during the 13-month capped rental period will be denied.
- In denying these claims, DME MACs will use the following Claim Adjustment Reason Code (CARC), and Remittance Advice Remark Codes (RARCs) messages for claims denied or rejected for DME repairs during the capped rental period:
    - CARC 97: "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. NOTE: refer to the 835 healthcare policy identification segment (loop 2110 service payment information ref), if present."
    - RARC MA13: "Alert: You may be subject to penalties if you bill the patient for amounts not reported with the Patient Responsibility (PR) group code." And
    - RARC N211: "Alert: You may not appeal this decision".

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

For complete details regarding this CR please see the official instruction (CR 7212) issued to your Medicare DME MAC. That instruction may be viewed by going to **http://www.cms.gov/Transmittals/downloads/R901OTN.pdf** on the Centers for Medicare and Medicaid Services (CMS) website.

To review the recent 2010 report from the Office of the Inspector General on this issue, you may go to **http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf** on the Internet.

July Quarterly Update for 2011 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM7416) (GEN)

MLN Matters® Number: MM7416
Related CR Release Date: June 3, 2011

Related CR Transmittal #: R2236CP

Related Change Request (CR) #: 7416
Effective Date: January 1, 2011, for fee schedule amounts for codes effective on that date; otherwise July 1, 2011
Implementation Date: July 5, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7416 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

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

Key Points of CR7416
Fees Added
The July Quarterly Update for the 2011 DMEPOS Fee Schedule Part B files established fee schedule amounts for Healthcare Common Procedure Coding System (HCPCS) codes A7020, E1831, and L5961, effective for claims with dates of service on or after January 1, 2011.

Note: *Claims for codes A7020, E1831, and L5961 with dates of service on or after January 1, 2011, that were previously processed may be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.*

Temporary "K" Codes
The following new K codes will be added to contractor's system effective for dates of service July 1, 2011:

- K0743 - SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
- K0744 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
- K0745 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
- K0746 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES

Note: *The addition of these codes does not imply any health insurance coverage. Medicare contractors will follow their normal processes in determining whether sufficient evidence exists to determine if these items are reasonable and necessary and covered under Medicare.*

Code Updates

- HCPCS code E0571 (AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER) will be made invalid for Medicare claims, effective July 1, 2011.
- The payment category for HCPCS code A4619 (FACE TENT) is being revised as part of this quarterly update to move this nebulizer accessory from the DME payment category for oxygen and oxygen equipment to the DME payment category for inexpensive or other routinely purchased items, effective July 1, 2011. The DMEPOS fee schedule file will be updated to reflect this change.

Payment for Oxygen Contents

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. After the 36-month rental payment period (cap), separate payment may be made for oxygen contents for the remainder of the equipment's reasonable useful lifetime. However, separate payment for oxygen contents ends when replacement stationary oxygen equipment is furnished causing a new 36-month rental payment period to begin. Also, separate oxygen contents payment is allowable for beneficiary-owned stationary or portable gaseous or liquid oxygen equipment. Beginning with dates of service on or after the end date of service for the month representing the 36th payment for the stationary oxygen equipment (codes E0424, E0439, E1390 or E1391), a supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

Oxygen Equipment Furnished in Month 36	Monthly Contents Payment after the Stationary Cap
Oxygen Concentrator (E1390, E1391, or E1392)	None
Portable Gaseous or Liquid Transfilling Equipment (K0738 or E0433)	None
E0424 Stationary Gaseous System	E0441 Stationary Gaseous Contents
E0439 Stationary Liquid System	E0442 Stationary Liquid Contents
E0431 Portable Gaseous System	E0443 Portable Gaseous Contents
E0434 Portable Liquid System	E0444 Portable Liquid Contents

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0433 or E0444) may begin following the stationary oxygen equipment payment cap AND before the end of the portable equipment cap (E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable equipment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparable damaged). **Under no circumstances would monthly payment be made for both stationary oxygen equipment and either stationary or portable oxygen contents.**

Proof-of-Delivery Requirements for Oxygen Contents

Following the oxygen equipment payment cap, oxygen content billing should be made on the anniversary date of the oxygen equipment billing.

At all times, the supplier is responsible for ensuring that the beneficiary has a sufficient quantity of oxygen contents and is never in danger of running out of contents. A maximum of 3 months of oxygen contents can be delivered to the beneficiary at one time and billed on a monthly basis. In these situations, the delivery date of the oxygen contents does not have to equal the date of service (anniversary date) on the claim, but in order to bill for contents for a specific month (i.e. the second or third month in the three month period), the supplier must have delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen, which may be less than monthly within the three month period. **If the supplier delivers more than one month of oxygen contents at a time (2 to 3), the supplier is not entitled to payment for additional months 2 and 3 if medical need ceases before the date when the supplier would be entitled to bill for those months.**

Payment for Replacement of Equipment After Repairs

Under the regulations at 42 CFR 414.210(e)(4), a supplier that transfers title to a capped rental DME item to the beneficiary is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if it is determined that the

item will not last until the end of its 5 year reasonable useful lifetime. In making this determination, Medicare contractors may consider whether the accumulated costs of repairing the item exceed 60 percent of the purchase fee schedule amount for the item.

Furthermore, 42 CFR 424.57(14) requires a DMEPOS supplier to maintain or replace a Medicare-covered item it has rented to beneficiaries to its intended status after being repaired. Recent cases have arisen whereupon after multiple repairs, the item continues to malfunction. CR7416 instructs your Medicare contractor to be aware of and educate suppliers of these regulatory requirements to replace DME items for which repairs have not restored the item. Also, after receipt of multiple repair claims, contractors will investigate suspicious claims for replacement equipment billed with its HCPCS code and the RA modifier.

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

The official instruction associated with this CR7416 issued to your Medicare Carrier, FI, DME MAC, RHHI or A/B MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2236CP.pdf** on the CMS website.

Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS): Allowing Contract or Non-contract Suppliers to Maintain and Service the Enteral Nutrition Equipment That They Provided in the 15th Continuous Month of Rental (MM7498) (SPE)

MLN Matters® Number: MM7498
Related CR Release Date: August 12, 2011
Related CR Transmittal #: R948OTN
Related Change Request (CR) #: 7498
Effective Date: January 1, 2011
Implementation Date: January 3, 2012

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for the maintenance and servicing of enteral nutrition equipment provided to Medicare beneficiaries.

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 7498 which outlines the requirements for the maintenance and servicing of enteral nutrition equipment under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

What You Need to Know
CR7498 states that Medicare beneficiaries with Original Medicare who obtain competitive bidding items in designated Competitive Bidding Areas (CBAs) are required to obtain these items from a contract supplier, unless an exception applies. If an enteral nutrition pump was rented for at least 15 continuous months at the time of the implementation of the competitive bidding program, the supplier that provided the pump in the 15th month of the rental period is responsible for furnishing, maintaining and servicing the pump after the 15th rental month and can be paid for the maintenance and servicing, regardless of their status as a winning or non-winning supplier. The payment can be made until either the pump is no longer medically necessary or the end of the reasonable useful lifetime is reached.

What You Need to Do
See the Key Points and Additional Information sections of this article for further details regarding these changes.

Key Points
- Claims will be paid when submitted by a National Competitive Bidding (NCB) contract or non-contract supplier for the maintenance and servicing of enteral nutrition pumps, provided the supplier furnished the pump to the beneficiary in the 15th month of continuous rental and provided that, in the case of a non-contractor supplier, the 15th month of rental occurred before the start of the competitive bidding round (January 1, 2011).

- Claims will be denied if submitted by non-contract suppliers for maintenance and servicing if the supplier did not provide the item in the 15th month of the rental period or if the 15th month occurred on or after the start of the competitive bidding round.

- For denied claims, DME MACs will supply the following messages on the remittance advice:
  - 96 - Non-covered charge(s).
  - M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
  - M114 - This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other demonstration project. For more information regarding this project, contact your local contractor.
  - N211 - Alert: You may not appeal this decision.
  - MA13 - Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
  - Group Code CO.

- Suppliers will be paid the Medicare payment amount for maintenance and servicing of enteral nutrition equipment equal to a percentage of the fee schedule for the purchase or rental of the enteral equipment, as applicable.

- For maintenance and servicing claims submitted by a non-contract supplier, Medicare Contractors will pay 50 percent of the fee schedule amount for a single month's rental of enteral nutrition equipment.

- For maintenance and servicing claims submitted by contract suppliers, Medicare Contractors will pay 5 percent of the single payment amount for the purchase of enteral nutrition equipment.

- Payments are allowed for maintenance and servicing of enteral nutrition equipment furnished by contract or non-contract suppliers until the earlier of either a determination is made by the beneficiary's physician that the equipment is no longer medically necessary or the end of the Reasonable Useful Lifetime (RUL) of the equipment.

- DMEPOS Competitive Bidding Program claims submitted by non-contract suppliers for maintenance and servicing of enteral nutrition equipment with dates of service between January 1, 2011, and December 31, 2011, and which were previously denied, will be reprocessed by your Medicare contractor if the supplier submitting the adjustment received payment for the 15th month of equipment rental prior to the start of the competitive bidding round.

Additional Information
The official instruction, CR7498 issued to your DME/ MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R948OTN.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.

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

MLN Matters® Number: MM7306 Revised
Related CR Release Date: June 22, 2011

Related CR Transmittal #: R908OTN

Related Change Request (CR) #: 7306
Effective Date: July 1, 2011, except October 1, 2011, for claims submitted to DME MACs
Implementation Date: July 5, 2011, except October 3, 2011, for claims submitted to DME MACs

Note: *This article was revised on June 23, 2011, to reflect a revised CR7306, which was issued on June 22. In this article, the effective and implementation dates have been revised for claims handled by DME MACs. Also, the CR release date, transmittal number and the Web address for accessing CR7306 have been revised. All other information is the same.*

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 (except October 2011 for DME MACs) 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.hhs.gov/Transmittals/downloads/R908OTN.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.

October 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7488) (DRU)

MLN Matters® Number: MM7488
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R2264CP
Related Change Request (CR) #: 7488
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7488, which instructs Medicare contractors to download and implement the October 2011 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised July 2011, April 2011, January 2011, and October 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 October 1, 2011, with dates of service October 1, 2011, through December 31, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

Files	Effective for Dates of Service
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010

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

The official instruction (CR 7488) issued to your Medicare MAC, carrier, and FI may be found at **http://www.cms.gov/Transmittals/downloads/R2264CP.pdf** on the CMS website.

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

MLN Matters® Number: MM7397 Revised
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R2271CP
Related Change Request (CR) #: 7397
Effective Date: October 1, 2011
Implementation Date: October 1, 2011

Note: *This article was revised on August 9, 2011, to reflect the revised CR7397 issued on August 5. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.*

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

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

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

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

- Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician's service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

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

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

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

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

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

Additional Information
The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at **http://www.cms.gov/Transmittals/downloads/R2271CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

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

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

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

MLN Matters® Number: MM7484
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R927OTN

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

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

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

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

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

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

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

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

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

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

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

Additional Information
You can find the official instruction, CR7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R927OTN.pdf** on the CMS website. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

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

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

Prospective Billing for Refills of DMEPOS Items Provided on a Recurring Basis (MM7452) (GEN)

MLN Matters® Number: MM7452
Related CR Release Date: July 1, 2011
Related CR Transmittal #: R378PI

Related Change Request (CR) #: 7452
Effective Date: August 2, 2011
Implementation Date: August 2, 2011

Provider Types Affected
Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for DMEPOS items and supplies that are provided on a recurring basis.

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

Background
For DMEPOS items and supplies that are provided on a recurring basis, billing must be based on prospective, not retrospective use. The following scenarios are illustrative of this concept:

- Scenario 1: The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order, delivers 100 units and bills the claim with a date of service as the date of delivery indicating 100 units. This is an example of prospective billing and is acceptable.
- Scenario 2: The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order and delivers 100 units. A claim is not billed. At the end of the month, the supplier determines that the beneficiary used 90 units for the month and delivers 90 units to replace the nutrient used. A claim is then submitted with a date of service as the date of delivery indicating 90 units of enteral nutrition. This is an example of retrospective billing and is not acceptable.

Additional Information
The official instruction, CR 7452 issued to your DME MAC regarding this issue may be viewed at **http://www.cms.gov/Transmittals/downloads/R378PI.pdf** on the Centers for Medicare & Medicaid Services (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.

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2011 Update (MM7303) (DRU)

MLN Matters® Number: MM7303
Related CR Release Date: May 24, 2011
Related CR Transmittal #: R2227CP

Related Change Request (CR) #: 7303
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Provider Types Affected
This article is for physicians, other providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know
CR7303 announces the quarterly updating of specific Health Care Procedure Code System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2011. You should make sure that your billing staffs are aware of these HCPCS code changes.

Non-payable Code
Effective for claims with dates of service on or after July 1, 2011, Medicare will not pay for the following HCPCS code:

HCPCS Code	Short Description	Long Description	Medicare Physician Fee Schedule Data Base (MPFSDB) Status Indicator
J7184	Wilate injection	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 100 I.U. VWF-RCO	I

Payable Codes
Contractors will accept the codes in the following table as payable HCPCS codes for dates of service on or after July 1, 2011, using Type of Service (TOS) 1, 9, and Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator "E" (Excluded from Physician Fee Schedule by Regulation):

HCPCS Code	Short Description	Long Description
Q2041	Wilate Injection	INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF-RCO
Q2042	Hydroxyprogesterone caproate	INJECTION, HYDROXYPROGESTERONE CAPROATE, 1 MG
Q2043	Sipuleucel-T auto CD54+	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION
Q2044	Belimumab injection	INJECTION, BELIMUMAB, 10 MG

Additional Information
You can find the official instruction, CR7303, issued to your Medicare contractor by visiting **http://www.cms.gov/Transmittals/downloads/R2227CP.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.

Fee Schedule Updates (GEN)

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

- 3rd Quarter 2011 Jurisdiction A DME MAC Fee Schedule
- 3rd Quarter 2011 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2011 Oral Anticancer Drug Fees

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

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

Join the NHIC, Corp. DME MAC A ListServe!

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

2012 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update (MM7552) (GEN)

MLN Matters® Number: MM7552
Related CR Release Date: August 26, 2011
Related CR Transmittal #: R2286CP

Related Change Request (CR) #: CR 7552
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
Physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

What You Need to Know
This article is based on Change Request (CR) 7552 which provides the 2012 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2011:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled 2012 Carrier/A/B MAC Update) will be posted at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill Fiscal Intermediaries or A/B MACs are advised that new Excel and PDF files (entitled 2011 FI/A/B MAC Update) will be posted to **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS website.

It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background
Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the "*Medicare Claims Processing Manual*" (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at **http://www.cms.gov/manuals/downloads/clm104c06.pdf** on the CMS website.

Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information
You can find the official instruction, CR7552, issued to your carrier, FI, A/B MAC, or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R2286CP.pdf** on the CMS website.

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

CMS Fraud Prevention Initiative (CMS Message 201108-27) (GEN)

Information You Need: CMS Fraud Prevention Initiative
If you help people with Medicare, Medicaid and the Children's Health Insurance Program (CHIP), you should know about an expanded federal government effort to reduce fraud and other improper payments in these health care programs to help ensure their long-term viability.

Significant progress in the fight against health care fraud has already been made as shown by the federal government's recovery of a record $4 billion last year from people who attempted to defraud seniors and taxpayers. The *Affordable Care Act* provides additional resources and tools to enable the Centers for Medicare & Medicaid Services (CMS) to expand efforts to prevent and fight fraud, waste and abuse. The CMS **Fraud Prevention Initiative** aims to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable services in all federal health care programs.

Fraud prevention efforts focus on moving CMS beyond its former "pay and chase" recovery operations to a more proactive "prevention and detection" model that will help prevent fraud and abuse before payment is made. A good example is the recent CMS announcement that for the first time, through the use of innovative predictive modeling technology similar to that used by credit card companies, the agency will have the ability to use risk scoring techniques to flag high risk claims and providers for additional review and take action to stop payments and remove providers from the program when necessary.

Yet, as important as these aggressive new initiatives are, the first and best line of defense against fraud remains the health care consumer. You can help by making sure that Medicare beneficiaries have the information they need to identify and report suspected fraud. This information is available in the **CMS Fraud Prevention Toolkit** on the web at **https://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp#TopOfPage**

The web site contains materials to help you inform Medicare beneficiaries about how to protect themselves from becoming a victim of fraud and how to report it. Thanks in advance for your assistance.

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

MLN Matters® Number: MM7389 Revised
Related CR Release Date: July 14, 2011
Related CR Transmittal #: R912OTN
Related Change Request (CR) #: 7389
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

NOTE: *This article was revised on July 18, 2011, to reflect the changes made to CR7389. The changes clarify that walkers are in the inexpensive or routinely purchased payment category and the rental period caps for the two payment categories (capped rental and inexpensive or routinely purchased) are calculated differently. The CR release date, transmittal number and Web link to access the CR have also changed. All other information remains the same.*

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

Provider Action Needed
Impact to You
This article is based on CR7389 which informs Medicare suppliers and DME MACs that Medicare payment is permissible to a non-contract, grandfathered supplier for furnishing certain purchased, covered accessories or supplies furnished for use with capped rental equipment.

What You Need to Know
There are limitations on the duration of this permission as well as constraints on the applicable Healthcare Common Procedure Coding System (HCPCS) codes. The KY modifier should not be annotated on claims for these HCPCS codes after September 30, 2011.

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

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

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

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

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

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

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

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

For rented, grandfathered equipment in the capped rental payment class (e.g. CPAP device), **after the rental payment cap for the grandfathered equipment is reached**:

- The beneficiary must obtain covered accessories and supplies (e.g. CPAP masks) only from a contract supplier;
- The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies;
- Medicare payment will no longer be made to a non-contract, grandfathered supplier for furnishing such purchased accessories or supplies; and

For rented, grandfathered equipment in the inexpensive or routinely purchased payment class, **after the total payments for the rented, grandfathered equipment (e.g. folding walker) reach the purchase fee schedule amount for the grandfathered equipment**:

- The beneficiary must obtain covered accessories (e.g. seat attachment) and supplies only from a contract supplier; and
- The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies once the capped rental payment cap is reached.

These claims will be denied, using the following messages:

- B20 - Procedure /service was partially or fully furnished by another provider;
- N211 - You may not appeal this decision; and
- M115 - This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

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

Note: *In all cases, payment for covered accessories and supplies used in conjunction with a grandfathered item is based on the single payment amount calculated for the item for the CBA in which the beneficiary maintains a permanent residence.*

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

The official instruction associated with this CR7389, issued to your Medicare MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R912OTN.pdf** on the CMS website.

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

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Expansion Announced (SE1127) (GEN)

MLN Matters® Number: SE1127
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation Date: NA

Provider Types Affected
This article is for suppliers of DMEPOS that wish to participate in the upcoming Round 2 of the Medicare DMEPOS Competitive Bidding Program and/or the National Mail-Order Competition for Diabetic Testing Supplies that will occur at the same time as Round 2.

What You Need to Know
This article provides important information from the Centers for Medicare & Medicaid Services (CMS) regarding the next phase (Round 2 and National Mail-Order) of Medicare's Competitive Bidding Program for DMEPOS. **If you are interested in bidding, prepare now - don't wait!**

The Round 2 product categories are:

- Oxygen, oxygen equipment, and supplies;
- Standard (Power and Manual) wheelchairs, scooters, and related accessories;
- Enteral nutrients, equipment, and supplies;
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beds and related accessories;
- Walkers and related accessories;
- Negative Pressure Wound Therapy pumps and related supplies and accessories; and
- Support surfaces (Group 2 mattresses and overlays).

CMS will also be conducting a national mail-order competition for diabetic testing supplies at the same time as the Round 2 competition. The national mail-order competition will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website, **http://www.dmecompetitivebid.com**, and the specific ZIP codes in each Round 2 competitive bidding area (CBA) are also available on the CBIC website.

UPDATE YOUR CONTACT INFORMATION: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update the following:

- The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding) and
- The correspondence address.

DMEPOS suppliers can update their enrollment via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the 7/11/2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS website at **http://www.cms.gov/MEDICAREPROVIDERSUPENROLL/** or reviewing the PECOS fact sheet at **http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf** on the CMS website.

Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website at **http://www.palmettogba.com/nsc** and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

GET LICENSED: Contracts are only awarded to suppliers that have all required state licenses at the time the bid is submitted. Therefore, before you submit a bid for a product category in a CBA, you must have all required state licenses for that product category on file with the NSC. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. **It is VERY IMPORTANT that current versions of all required licenses are in your enrollment file with the NSC BEFORE you bid.** If any required licenses are expired or missing from your enrollment file, CMS can reject your bid. Suppliers bidding in the National Mail-Order Competition must have the applicable licenses for all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

GET ACCREDITED: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action NOW to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited by a CMS-approved accreditation organization.

Current Round 2 and National Mail-Order Schedule
CMS has announced the following next steps for the program to ensure that suppliers have ample time to prepare for the competition:

Summer 2011

- CMS begins pre-bidding supplier awareness program;

Fall 2011

- CMS announces bidding schedule;
- CMS begins bidder education program; and
- Bidder registration period to obtain user ID and passwords begins.

Winter 2012

- Bidding begins.

Additional Information
The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed - visit the CBIC website at **http://www.dmecompetitivebid.com/** to subscribe to e-mail updates and for the latest information.

For more information on the DMEPOS competitive bidding program, visit **http://www.cms.gov/dmeposcompetitivebid/** on the CMS website.

Information on the DMEPOS accreditation requirements along with a list of the accreditation organizations and those professionals and other persons exempted from accreditation may be found at **http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp** on the CMS website.

The press release about the expanded competitive bidding program may be found at **http://www.cms.gov/apps/media/press_releases.asp** on the CMS website.

To view the Fact Sheet titled: Next Steps For Expansion Of The Medicare Durable Medical Equipment, Prosthetics, Orthotics, And Supplies go to **http://www.cms.gov/apps/media/fact_sheets.asp** on the CMS website.

Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696) (SE1011) (GEN)

MLN Matters Number: SE1011 Revised
Related CR Release Date: N/A
Related CR Transmittal #: R642OTN, R643OTN, and R328PI

Related Change Request (CR) #: 6421, 6417, and 6696
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on August 15, 2011, to delete doctors of chiropractic medicine from the list of providers on page 3 who are eligible to order and refer items or services for Medicare beneficiaries. This article was revised on November 26, 2010 to include the following statement: The Centers for Medicare & Medicaid Services (CMS) previously announced that, beginning January 3, 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 will not be turned on effective January 3, 2011.*

Provider Types Affected
Physicians, non-physician practitioners (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider Action Needed
If you order or refer items or services for Medicare beneficiaries and you do not have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855I). If you reassign your Medicare benefits to a group or clinic, you will also need to complete the CMS-855R.

What Providers Need to Know
Phase 1: Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim will not be paid. If the ordering/referring provider is reported on the claim but does not have a current enrollment record in PECOS or is not of a specialty that is eligible to order and refer, the claim will be paid and the billing provider will receive an informational message in the remittance indicating that the claim failed the ordering/referring provider edits.

Phase 2: Beginning January 3, 2011 (**See statement on page one delaying implementation of phase 2.**), Medicare will reject Part B claims that fail the Ordering/Referring Provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment records in PECOS and must be of a specialty that is eligible to order and refer.
Enrolled physicians and non-physician practitioners who do not have enrollment records in PECOS and who submit enrollment applications in order to get their enrollment information into PECOS should not experience any disruption in Medicare payments, as a result of submitting enrollment applications.

Enrollment applications must be processed in accordance with existing Medicare instructions. It is possible that it could take 45-60 days, sometimes longer, for Medicare enrollment contractors to process enrollment applications. All enrollment applications, including those submitted over the web, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application.

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the Ordering/Referring Provider edits, which is January 3, 2011.

Background
The Centers for Medicare & Medicaid Services (CMS) has implemented edits on Ordering and Referring Providers when they are required to be identified in Part B claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

- Below are examples of some of these types of claims:
  - Claims from laboratories for ordered tests;
  - Claims from imaging centers for ordered imaging procedures;
  - Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS; and
  - Claims from specialists or specialty groups for referred services.

- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:
  - Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
  - Physician Assistant,
  - Certified Clinical Nurse Specialist,
  - Nurse Practitioner,
  - Clinical Psychologist,
  - Certified Nurse Midwife, and
  - Clinical Social Worker.

Questions and Answers Relating to the Edits

1. What will the edits do?

The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e., the enrollment record is in PECOS and it contains the National Provider Identifier (NPI)), and (2) is of a type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. How and when will these edits be implemented?

These edits are being implemented in two phases:

- **Phase 1** began on October 5, 2009, and is scheduled to end on January 2, 2011. In Phase 1, if the Ordering/Referring Provider does not pass the edits, the claim will be processed and paid (assuming there are no other problems with the claim) but the Billing Provider (the provider who furnished the item or service that was ordered or referred) will receive an informational message[1] from Medicare in the Remittance Advice[2].

  The informational message will indicate that the identification of the Ordering/Referring provider is missing, incomplete, or invalid, or that the Ordering/Referring Provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication.

  Note: *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.*

- **Phase 2** is scheduled to begin on January 3, 2011, and will continue thereafter. In Phase 2, if the Ordering/Referring Provider does not pass the edits, the claim will be rejected. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral.

CMS has taken actions to reduce the number of informational messages.

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.[3]

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a periodic basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report, and to download it, go to **http://www.cms.gov/MedicareProviderSupEnroll**; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

[1] The informational messages vary depending on the claims processing system.
[2] DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.
[3] NPIs were added only when the matching criteria verified the NPI.

Effect of Edits on Providers

A. I order and refer. How will I know if I need to take any sort of action with respect to these two edits?

In order for the claim from the Billing Provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you—the Ordering/Referring Provider—need to ensure that:

1. You have a current Medicare enrollment record (that is, your enrollment record is in PECOS and it includes your NPI).
   - If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in 6 or more years, you do not have an enrollment record in PECOS. You need to take action to establish one. See the last bullet in this section.
   - If you are not sure, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not have an enrollment record in PECOS). If you choose (3), please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
   - **If you do not have an enrollment record in PECOS:**
     - You need to submit an enrollment application to Medicare in one of two ways:
       a. **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to print, sign, and date the Certification Statement and mail the Certification Statement, and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to **http://www.cms.gov/MedicareProviderSupEnroll**, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.

NOTE for physicians/non-physician practitioners who reassign all their Medicare benefits to a group/clinic: If you reassign all of your Medicare benefits to a group/clinic, the group/clinic must have an enrollment record in PECOS in order for you to enroll via the web. You should check with the officials of the group/clinic or with your designated Medicare enrollment contractor if you are not sure if the group/clinic has an enrollment record in PECOS. If the group/clinic does not have an enrollment record in PECOS, you will not be able to use the web to submit your enrollment application to Medicare. You will need to submit a paper application, as described in the bullet below.

b. **Obtain a paper enrollment application (CMS-855I)**, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you reassign all your Medicare benefits to a group/clinic, you will also need to fill out, sign and date the CMS-855R, obtain the signature/date signed of the group's Authorized Official, and mail the CMS-855R, along with the CMS-855I, to the designated Medicare enrollment contractor. Enrollment applications are available for downloading from the CMS forms page (**http://www.cms.gov/cmsforms**) or by contacting your designated Medicare enrollment contractor.

NOTE about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

2. **You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.** When you enrolled in Medicare, you indicated your Medicare specialty. **Any** physician specialty and **only** the non-physician practitioner specialties listed above in this Article are eligible to order or refer in the Medicare program.

B. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?

As the Billing Provider, you need to ensure that your Medicare claims for items or services that you furnished based on orders or referrals will pass the two edits on the Ordering/Referring Provider so that you will not receive informational messages in Phase 1 and so that your claims will be paid in Phase 2.

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have enrollment records in PECOS that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article. Ensure you are correctly spelling the Ordering/Referring Provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits. Keep in mind that this Ordering Referring Report will be replaced about once a month to ensure it is as current as practicable. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may resubmit a claim that did not initially pass the Ordering/Referring Provider edits.

Make sure your claims are properly completed. Do not use "nicknames" on the claim, as their use could cause the claim to fail the edits (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). Do not enter a credential (e.g., "Dr.") in a name field. On paper claims (CMS-1500), in item 17, you should enter the Ordering/Referring Provider's first name first, and last name second (e.g., John Smith). Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral. Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer. If there are additional questions about the informational messages, Billing Providers should contact their local carrier, A/B MAC, or DME MAC.

Billing Providers should be aware that claims that are rejected because they failed the Ordering/Referring Provider edits are not denials of payment by Medicare that would expose the Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate.**

Additional Guidance

1. **Orders or referrals by interns or residents.** Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/she may not be identified in a Medicare claim as the Ordering/Referring Provider. The teaching, admitting, or supervising physician is considered the Ordering/Referring Provider when interns and residents order and refer, and that physician's name and NPI would be reported on the claim as the Ordering/Referring Provider.

2. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare.** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

3. **Orders or referrals by dentists.** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review the following related CRs:

- CR 6417 at **http://www.cms.gov/Transmittals/downloads/R825OTN.pdf** on the CMS website;
- CR 6421 at **http://www.cms.gov/Transmittals/downloads/R823OTN.pdf** on the CMS website; and
- CR 6696 at **http://www.cms.gov/Transmittals/downloads/R328PI.pdf** on the CMS website.

If you have questions, please contact your Medicare carrier, Part A/B Medicare Administrative Contractor (A/B MAC), or durable medical equipment Medicare Administrative Contractor (DME/MAC), at their toll-free numbers, 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 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 August 15, 2011, to delete chiropractors from the list of providers on page 2 who may order and/or refer. All other information remains the same. In the near future, CR6417 will be revised to remove chiropractors from that CR's list of providers who may order and/or refer. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice*

before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "To Be Announced" implementation and effective dates in this article are the correct dates.

Provider Types Affected
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;
- 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 August 15, 2011, to delete chiropractors from the list of providers on page 2 who may order and/or refer. All other information remains the same. In the near future, CR6421 will be revised to remove chiropractors from that CR's list of providers who may order and/or refer. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "To Be Announced" implementation and effective dates in this article are the correct dates.*

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

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

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

The providers who can order/refer are:

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

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

Key Points

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

    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.**

    2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.**

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

    1. **If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.**

2. **If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.**

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

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

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

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

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

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

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

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R823OTN.pdf** on the CMS website.

Foot Care Coverage Guidelines (SE1113) (SPE)

MLN Matters Number: SE1113
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected
This article is for informational purposes only for providers billing Medicare for foot care services. It is an overview of existing policy and no change in policy is being conveyed.

Medicare Podiatry Services
The scope of the practice for Podiatry is defined by state law and the individual state laws should be consulted in determining a specific podiatrist's (or doctor of podiatric medicine) scope of practice.
This article covers routine care of the foot as well as care related to underlying systemic conditions such as metabolic, neurologic or peripheral vascular disease, or injury, ulcers, wounds, and infections.

Medicare Covered Foot Care Services
According to the "*Medicare Benefit Policy Manual*" (MBPM), Chapter 15, Section 290, Medicare covered foot care services only include medically necessary and reasonable foot care.

Exclusions from Coverage
Certain foot care related services are not generally covered by Medicare. In general, the following services, whether performed by a podiatrist, osteopath, or doctor of medicine, and without regard to the difficulty or complexity of the procedure, **are not covered by Medicare**:

1. Treatment of Flat Foot
The term "flat foot" is defined as a condition in which one or more arches of the foot have flattened out. Services or devices directed toward the care or correction of such conditions, including the prescription of supportive devices, are not covered.

2. Routine Foot Care
Except as discussed below in the section entitled "*Conditions that Might Justify Coverage*", routine foot care is excluded from coverage. Services that normally are considered routine and not covered by Medicare include the following:

- The cutting or removal of corns and calluses;
- The trimming, cutting, clipping, or debriding of nails; and
- Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot.

3. Supportive Devices for Feet
Orthopedic shoes and other supportive devices for the feet generally are not covered, except Medicare does cover such a shoe if it is an integral part of a leg brace, and its expense is included as part of the cost of the brace. Also, a narrow exception permits coverage of special shoes and inserts for certain patients with diabetes.

Conditions that Might Justify Coverage
The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine (and, therefore, excluded from coverage). Accordingly, foot care that would otherwise be considered routine may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet. In these instances, certain foot care procedures that otherwise are considered routine (e.g., cutting or removing corns and calluses, or trimming, cutting, clipping, or debriding nails) may pose a hazard when performed by a nonprofessional person on patients with such systemic conditions.
Although not intended as a comprehensive list, the following metabolic, neurologic, and peripheral vascular diseases (with synonyms in parentheses) most commonly represent the underlying conditions that might justify coverage for routine foot care:

- Diabetes mellitus *
- Arteriosclerosis obliterans (A.S.O., arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitis obliterans)
- Chronic thrombophlebitis *
- Peripheral neuropathies involving the feet
    - Associated with malnutrition and vitamin deficiency *
        - Malnutrition (general, pellagra)
        - Alcoholism
        - Malabsorption (celiac disease, tropical sprue)
        - Pernicious anemia
    - Associated with carcinoma *
    - Associated with diabetes mellitus *
    - Associated with drugs and toxins *
    - Associated with multiple sclerosis *
    - Associated with uremia (chronic renal disease) *
    - Associated with traumatic injury
    - Associated with leprosy or neurosyphilis
    - Associated with hereditary disorders
        - Hereditary sensory radicular neuropathy

- Angiokeratoma corporis diffusum (Fabry's)
- Amyloid neuropathy

When the patient's condition is one of those designated above by an asterisk (*), routine procedures are covered only if the patient is under the active care of a doctor of medicine or osteopathy who documents the condition.

In addition, the following may be covered:

- The treatment of warts (including plantar warts) on the foot is covered to the same extent as services provided for the treatment of warts located elsewhere on the body.
- In the absence of a systemic condition, treatment of mycotic nails may be covered. **The treatment of mycotic nails for an ambulatory patient** is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. **The treatment of mycotic nails for a nonambulatory patient** is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

Presumption of Coverage for Routine Services

When evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For the purposes of applying this presumption, please refer to the "*Medicare Benefit Policy Manual*", Chapter 15, Section 290.

When the routine services are **rendered by a podiatrist**, your Medicare carrier may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the six-month period prior to the rendition of the routine-type services.

The carrier may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with the podiatrist's findings as to the severity of the peripheral involvement indicated.

Foot Care for Patients with Chronic Disease

Diabetic Sensory Neuropathy: Loss of Protective Sensation (LOPS)

Effective for services furnished on or after July 1, 2002, Medicare covers an evaluation (examination and treatment) of the feet no more often than every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS, as long as the beneficiary has not seen a foot care specialist for some other reason in the interim.

The diagnosis of diabetic sensory neuropathy with LOPS should be established and documented prior to coverage of foot care. Other causes of peripheral neuropathy should be considered and investigated by the primary care physician prior to initiating or referring for foot care for persons with LOPS.

Please refer to the "National Coverage Determination (NCD), entitled "Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (LOPS) (aka Diabetic Peripheral Neuropathy)" for more information. This NCD is available at
http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=171&ncdver=1&bc=BAAAgAAAAAAA&
on the Centers for Medicare & Medicaid Services (CMS) website.

Lower Extremity Wound Care

Electrostimulation and Electromagnetic Therapy for Wounds (Claims submitted on or after July 6, 2004)

The Centers for Medicare & Medicaid Services (CMS) will allow for coverage for the use of electrical stimulation and electromagnetic therapy for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers when certain conditions are met

For more detailed information, please refer to National Coverage Determination (NCD) for "Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds," which can be found at
http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=131&ncdver=3&bc=BAABAAAAAAAA
on the CMS website.

Hyperbaric Oxygen (HBO) Therapy for Hypoxic Wounds and Diabetic Wounds of the Lower Extremities (CAG-00060N)
For claims submitted on or after April 1, 2000, HBO therapy in the treatment of diabetic wounds of the lower extremities will be covered in patients who meet each of the following three criteria. Patient has:

- Type I or Type II Diabetes and has a lower extremity wound that is due to diabetes;
- A wound classified as Wagner grade III or higher; and has
- Failed an adequate course of standard wound therapy (defined below).

The use of HBO therapy will be covered as adjunctive therapy **only after there are no measurable signs of healing for at least 30-days of treatment with standard wound therapy** and must be used in addition to standard wound care.

Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

For more information about HBO therapy for diabetic wounds of the lower extremities, please refer to the NCD for Hyperbaric Oxygen Therapy, which is available at **http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=12&ncdver=3&NCAId=37&ver=7&NcaName=Hyperbaric+Oxygen+Therapy+for+Hypoxic+Wounds+and+Diabetic+Wounds+of+the+Lower+Extremities&fromdb=true&IsPopup=y&bc=AAAAAAAAEAgA&** on the CMS website.

Additional Billing Guidelines
Claims Involving Complicating Conditions

- When submitting claims for services furnished to Medicare beneficiaries who have complicating conditions, **the name of the M.D. or D.O. who diagnosed the complicating condition must be submitted with the claim**, along with the **approximate date** that the beneficiary was last seen by the indicated physician.

- Document carefully any convincing evidence showing that non-professional performance of a service would have been hazardous for the beneficiary because of an underlying systemic disease. Stating that the beneficiary has a complicating condition such as diabetes does not of itself indicate the severity of the condition.

- Exceptional situations include initial diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only non-covered care.

- The exclusion of foot care is **determined by the nature of the service** and not according to who provides the service. When an itemized bill shows both covered services and non-covered services that are not integrally related to the covered service, the portion of the charges that are attributable to the non-covered services should be denied.

- Sometimes payment is made for incidental non-covered services that are performed as a necessary and integral part of, and secondary to, a covered procedure. For example, if toenails must be trimmed in order to apply a cast to a fractured foot, then the charge for the trimming of nails would be covered.

- However, a separately itemized charge for this excluded service would not be allowed. Please refer to your Medicare contractor for questions about coverage that is "incident to" a covered procedure.

- Information about coverage **Incident to Physician's Professional Services** can also be found in the "*Medicare Benefit Policy Manual*," Chapter 15, Covered Medical and Other Health Services, Section 60 - Services and Supplies.

Therapeutic Shoes for Individuals with Diabetes (MBPM, Chapter 15, Section 140)

- Coverage of depth or custom-molded therapeutic shoes and inserts for individuals with diabetes is available as of May 1, 1993.

- These diabetic shoes are covered if the requirements specified in the "*Medicare Benefits Policy Manual*," Chapter 15, Section 140, regarding certification and prescription are met.

- This benefit provides for a pair of diabetic shoes each equipped so that the affected limb, as well as the remaining limb, is protected, , even if only one foot suffers from diabetic foot disease.

- Claims for therapeutic shoes for diabetics are processed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Therapeutic shoes for diabetics are not DME and are not considered DME or orthotics, but a separate category of coverage under Medicare Part B.

Related Links

Medicare Manuals

The "*Medicare Benefit Policy Manual*," Publication 100-2, Chapter 15, can be found at **http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf** on the CMS website.

The "*Medicare Program Integrity Manual*" can be found at **http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf** on the CMS website.

The "*National Coverage Determination Manual*" can be found at **http://www.cms.gov/Manuals/IOM/itemdetail.asp?itemID=CMS014961** on the CMS website.

Local Coverage Decisions

The Medicare Coverage Database provides access to local coverage decision articles published for Medicare contractors. These articles can be found at **http://www.cms.hhs.gov/mcd/index_local_alpha.asp?from=alphaarticle&letter=P** on the CMS website.

Related Change Requests and MLN Matters Articles

Program Memorandum Transmittal AB-02-096, Change Request 2269, "*Coverage and Billing of the Diagnosis and Treatment of Peripheral Neuropathy with Loss of Protective Sensation in People with Diabetes*" can be found at **http://www.cms.hhs.gov/Transmittals/downloads/AB02096.pdf** on the CMS website.

Program Memorandum Transmittal AB-02-105, Change request 2272, "*Medical Review of Medicare Payments for Nail Debridement Services*," can be found at **http://www.cms.hhs.gov/Transmittals/Downloads/AB02105.pdf** on the CMS website.

MLN Matters article, MM3430, "*Reasonable charge update for 2005 splints, casts, dialysis supplies, dialysis equipment, therapeutic shoes and certain intraocular lenses*" can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3430.pdf** on the CMS website.

Provider Services Portal (PSP)

NHIC, Corp. has been receiving requests to have a program that DME MAC Jurisdiction A suppliers can use to easily access beneficiary eligibility and claims information over the internet. We are pleased to announce that the PSP is **now available for open enrollment!** If you are interested in becoming a PSP participant visit:

http://www.medicarenhic.com/dme/dme_psphome_index.shtml

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

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

Note: *This article was revised on August 10, 2011, to provide the correct section number of the Affordable Care Act that requires the revalidation. The correct section is 6401 (a) and not 6401 (d) as originally noted. All other information remains the same.*

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

Provider Action Needed
Impact to You
In Change Request (CR) 7350, the Centers for Medicare & Medicaid Services (CMS) discussed the final rule with comment period, titled, "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the "Federal Register." A related MLN Matters® Article is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf** on the CMS website. **This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the Affordable Care Act.**

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

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

- Update your enrollment through Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or complete the 855;
- Sign the certification statement on the application;
- If applicable, pay your fee thru pay.gov; and
- Mail your supporting documents and certification statement to your MAC.

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

Background
Section 6401 (a) of the *Affordable Care Act* established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation effort applies to those providers and suppliers that were enrolled prior to March 25, 2011. **Newly enrolled providers and suppliers that submitted their enrollment applications to CMS on or after March 25, 2011, are not impacted. Between now and March 23, 2013, MACs will send out notices on a regular basis to begin the revalidation process for each** - provider and supplier. **Providers and suppliers must wait to submit the revalidation only after being asked by their MAC to do so.** Please note that 42 CFR 424.515(d) provides CMS the authority to conduct these off-cycle revalidations.

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

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

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

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

All institutional providers and suppliers who respond to a revalidation request must submit an enrollment fee via Pay.Gov (reference 42 CFR 424.514). You may submit your fee by electronic check, debit, or credit card. Revalidations are processed only when fees have cleared. To pay your application fee, go to **http://www.pay.gov** and type "CMS" in the search box under Find Public Forms, and click the GO button. Click on the CMS Medicare Application Fee link. Complete the form and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you mail this receipt to the Medicare contractor along with the Certification Statement for the enrollment application. CMS will notify the Medicare contractor that the application fee has been paid.

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

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

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

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

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

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

Guidelines to Allow Contractors to Develop and Utilize Procedures for Accepting and Processing Reopenings via a Secure Internet Portal/Application (MM7420) (GEN)

MLN Matters® Number: MM7420
Related CR Release Date: June 17, 2011
Related CR Transmittal #: R2241CP

Related Change Request (CR) #: CR 7420
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

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

Provider Action Needed

Impact to You

Effective October 1, 2011, you may have (depending on your contractor) an alternative, electronic method to submit your requests for Medicare Fee-For-Service (FFS) claim reopenings.

What You Need to Know

CR7420, from which this article is taken (effective October 1, 2011,) allows Medicare contractors to use a secure Internet portal/application to accept and process your requests for reopening Medicare FFS claims.

What You Need to Do

You should make sure that your billing staffs are aware of this change.

Background

In response to requests from Medicare contractors, CR7420 (from which this article is taken) updates the current instructions in the "*Medicare Claims Processing Manual*" Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), to allow them to accept claimant initiated reopening requests via a secure Internet portal/application - effective October 1, 2011. (You can find this manual at **http://www.cms.gov/manuals/downloads/clm104c34.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.)

Note: *Medicare contractors may not require you to file a reopening via a secure Internet portal/application. Also, contractors are not required to offer this electronic capability.*

Medicare will have a number of requirements for Medicare contractors utilizing a secure Internet portal/application for reopening. Specifically, to provide this access, contractors will:

- Incorporate a formal registration process that contains validation of the electronic signature on the reopening request, which will include, at a minimum, the use of restricted user identifiers (IDs) and passwords, and a method for authenticating that the party has completed the portal registration process and has been properly identified by the system as an appropriate user.

- Include, in the appeals case file, an indication and/or description of the validation methodology; should a redetermination and/or higher level of appeal be submitted following an adverse reopening decision.

- Ensure that secure Internet portal/applications developed for reopening activities adhere to the security standards in the *Health Insurance and Portability and Accountability Act (HIPAA)*; and comply with all CMS security requirements regarding protected health information prior to implementation.

- Issue a reopening decision or refusal to reopen via a secure Internet portal/application only if the party has submitted the request for reopening through that application.

- Provide adequate education to participating parties:
  - Regarding system capabilities/limitations prior to implementation and utilization of the secure portal; and
  - Reminding them that participation/enrollment in the secure portal/application is at their discretion and that they bear the responsibility for the authenticity of the information being attested to in the request.

- Include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this will include a statement indicating that the document was, "electronically signed by" or "verified/approved by," etc.

- Ensure that appropriate procedures are in place, via the secure Internet/portal, to provide parties to the reopening with receipt confirmation of the reopening request, and instructions not to submit additional reopening requests for the same item/service via different venue (i.e., telephone, in writing, etc.).

- Consider decisions processed via a CMS approved secure Internet portal/application complete on the date the electronic reopening decision notice is transmitted to the party through the secure Internet portal/application.

- Ensure that there is a process in place by which a party can submit, via the secure application/portal; additional documentation/materials concurrent with the reopening request (i.e. ensure that the portal/application has the capability to accept additional documentation and/or other materials to support the reopening request.)

- Include a mechanism that tracks and marks the date/time of the notification so the submitting party is adequately informed about the timeframes required to ensure timely submission of future appeal requests for the item/service at issue, if applicable; and ensure that parties may save and print the refusal to reopen notice and the adverse revised determination/decision notice.

- Ensure that refusal to reopen and adverse revised determination notices transmitted via a secure Internet portal/application comply with the timeliness and content requirements as outlined in the "*Medicare Claims Processing Manual*," Chapter 34.

- Provide hard copy adverse revised determination/decision notices to parties to the reopening who do not have access to the secure Internet portal/application; and ensure that these notices are mailed and/or otherwise transmitted on the same day the notice is transmitted via the secure portal/application.)

- Include the adverse revised determination/decision notice and any other related materials in the appeals case file if a valid appeal on the item/service is later requested.

Contractors will not issue a refusal to reopen notice if they begin processing a valid and timely request for redetermination as a reopening (clerical error or otherwise) and later determine that a reopening cannot be performed, or the determination cannot be changed. Rather, they will process the request as a valid/timely redetermination (as originally requested by the party) in accordance with the "*Medicare Claims Processing Manual*," Chapter 29 (Appeals of Claims Decisions), which you can find at **http://www.cms.gov/manuals/downloads/clm104c29.pdf** on the CMS website.

Additional Information
You can find the official instruction, CR7420, issued to your FI or A/B MAC by visiting **http://www.cms.gov/transmittals/downloads/R2241CP.pdf** on the Centers for Medicare & Medicaid (CMS) website.

You will find the updated "*Medicare Claims Processing Manual*," Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), Sections 34.10 (Reopenings and Revisions of Claims Determinations and Decisions-General), 34.10.1 (Authority to Conduct a Reopening), 34.10.6.4 (Timeframes When a Party Requests an Adjudicator Reopen Their Decisions), 34.10.7 (Timeframes to Complete a Reopening Requested by a Party), 34.10.8 (Notice of a Revised Determination or Decision), and 34.10.13 (System and Processing Requirements for Use of Secure Internet Portal/Application to Support Reopening Activities) as an attachment to that CR.

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

Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) (MM7454) (GEN)

MLN Matters® Number: MM7454
Related CR Release Date: June 24, 2011
Related CR Transmittal #: R2246CP

Related Change Request (CR) #: 7454
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected
All Medicare providers and suppliers submitting claims to Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), Carriers, A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment (DME) MACs are affected by this article.

Provider Action Needed
This article, based on Change Request (CR) 7454, informs you that the Centers for Medicare & Medicaid Services (CMS) is providing its annual reminder of the ICD-9-CM update that is effective for the dates of service on and after October 1, 2011 (effective for discharges on or after October 1, 2011, for institutional providers). Please be sure to inform your staffs of these updates.

Background
ICD-9 Information
The ICD-9-CM codes are updated annually. Effective since October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare contractors and MACs, with the exception of ambulance claims (specialty type 59).

CMS posts the new, revised and discontinued ICD-9-CM diagnosis codes annually at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage** on the CMS website. The updated diagnosis codes are effective for dates of service and discharges on and after October 1. You may view the new updated codes at this site in June. You may also visit the National Center for Health Statistics (NCHS) website at **http://www.cdc.gov/nchs/icd.htm** on the Internet. The NCHS will post the new ICD-9-CM Addendum on their website in June. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM annually.

International Classification of Diseases, Tenth Revision (ICD-10) Information
CMS has posted a list of **2011** ICD-10-CM code descriptions in tabular order (the order they appear in the code book) at **http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMs.asp** on the CMS website. The tabular order version of ICD-10-CM will assist those who wish to identify a range of codes and make certain they have correctly identified all codes within the range. In addition, a list of 2012 ICD-10-PCS codes is at **http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp** on the CMS site. The 2012 ICD-10-CM list should be posted later this year and its posting will be conveyed via listserv notices.

Additional Information
The official instruction, CR 7454, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R2246CP.pdf** on the CMS website.

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

Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1 (MM7466) (GEN)

MLN Matters® Number:MM7466
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R926OTN
Related Change Request (CR) #: 7466
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
This article is for physicians, providers, and suppliers using the Medicare Remit Easy Print (MREP) and PC Print software in relation to remittance advices they receive from Medicare contractors (carriers, Fiscal Intermediaries (FIs), DME 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
MREP and PC Print have been updated to include the latest enhancements as part of implementing version 5010A1 for Transaction 835 - Health Care Claim Payment/Advice. Specifically:

- The MREP User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1; and
- The PC Print User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1 version for ASC X12 Transaction 835.

If you use MREP or PC Print, be sure to download the updated user guide for 835 version 5010A1 when they are available.

Background
The Centers for Medicare and Medicaid Services (CMS) is implementing the new standard for Transaction 835 (Health Care Claim Payment/Advice) Version 5010A1 adopted under the *Health Insurance Portability and Accountability Act (HIPAA)*. Providers/Suppliers

must transition to the new version on or before January 1, 2012. CMS has made MREP and PC Print software available to providers/suppliers to enable them to view/print/download the electronic remittance advice in version 5010A1 in a human readable format.

Additional Information
The official instruction, CR7466 issued to your carrier, FI, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R926OTN.pdf** on the CMS website. For more information on the Version 5010 transition and implementation, visit **http://www.cms.gov/Versions5010andD0/** on the CMS website.

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

Phase 3 of Manual Revisions to Reflect Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items as a Result of the DMEPOS Competitive Bidding Program and the Deficit Reduction Act of 2005 (MM7401) (GEN)

MLN Matters® Number: MM7401
Related CR Release Date: May 27, 2011
Related CR Transmittal #: R2231CP

Related Change Request (CR) #: 7401
Effective Date: August 28, 2011
Implementation Date: August 28, 2011

Provider Types Affected
This article is for Medicare DMEPOS suppliers that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as well as providers that bill Medicare Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for DMEPOS that they refer or order for Medicare beneficiaries.

What You Need to Know
Change Request (CR) 7401, from which this article is developed, is the third installment of, and adds information to, Chapter 36 DMEPOS Competitive Bidding Program in the "*Medicare Claims Processing Manual*" and provides additional information for Medicare contractors and suppliers on the Round One Rebid Implementation. CR 5978 provided the first installment of Chapter 36 and details the initial requirements of this program. The phase one MLN Matters® article CR5978 is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM5978.pdf** on the Centers for Medicare & Medicaid services (CMS) website. CR 6119 provided the second installment of Chapter 36 and details the second phase of the manual revisions to this program. The related MLN Matters® article CR6119 is available at **http://www.cms.gov/MLNMattersArticles/Downloads/MM6119.pdf** on the CMS website.

Background
The Medicare payment for most DMEPOS was traditionally based on fee schedules. When section 1847 of the *Social Security Act* (the Act), section 302(b) of the *Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA)* was amended, a competitive bidding program was implemented to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items that are subject to competitive bidding under this statute.

CMS issued the regulation for the competitive bidding program on April 10, 2007 (72 Federal Register 17992). Round One of the National Competitive Bidding (NCB) Program was implemented on January 1, 2011. CR 7401 provides additional instructions on changes under the DMEPOS Competitive Bidding Program. This regulation is available at **http://www.cms.hhs.gov/DMEPOSCompetitiveBid** on the CMS website.

Key Points of CR7401
There are seven additions to section 50 of Chapter 36 of the "*Medicare Claims Processing Manual*"; one is an update and the other six are new additions:

- Section 50.3 is updated to include new HCPCS modifiers developed to facilitate implementation of various policies that apply to certain competitive bidding items. The KG, KK, KU, KW, and KY modifiers are pricing modifiers that suppliers must use to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories.
    - 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 must submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category must use the KK modifier. All suppliers, including grandfathered suppliers, shall submit claims for competitive bid items using the aforementioned competitive bidding modifiers.
    - The KG and KK modifiers are used in Round I of the competitive bidding program and the KU and KW modifiers are reserved for future program use.

The six sections added to Chapter 36: 50.10 through 50.15 as follows:

- 50.10 - Claims Submitted for Hospitals Who Furnish Competitively Bid Items;
    - Under DMEPOS Competitive Bidding, hospitals may furnish certain types of competitively bid DME to their patients on the date of discharge without submitting a bid and being awarded a contract. The DME items that a hospital may furnish as part of the exception are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. Payment for items furnished under this exception will be made based on the single payment amount for the item for the Competitive Bidding Area (CBA) where the beneficiary resides. Separate payment is not made for walkers and related accessories furnished by a hospital on the date of admission because payment for these items are included in the Part A payment for inpatient facility services. Refer to the "*Medicare Claims Processing Manual*", Chapter 1, 10.1.1.1 for instructions for submitting claims at **http://www.cms.gov/manuals/downloads/clm104c01.pdf** on the CMS website.

- 50.11 - Claims Submitted for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan;
    - Under DMEPOS Competitive Bidding, if a beneficiary resides in a CBA and elects to leave their MA plan or loses his/her coverage under this plan, the beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program. However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier, meet the Medicare Fee-For-Service coverage criteria and documentation requirements, and must elect to become a grandfathered supplier. All competitive bid grandfathering rules apply in these situations.

- 50.12 - Claims for Repairs and Replacements;
    - Under the DMEPOS Competitive Bidding Program, any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA. In these situations, Medicare payment for labor will be made based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment that are submitted with the RB modifier will be based on the single payment amount for the part, if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.
    - **The replacement of an entire item, as opposed to the replacement of a part for repair purposes, which is subject to the DMEPOS Competitive Bidding Program, must be furnished by a contract supplier.** Medicare payment for the replacement item would be based on the single payment amount for the item in the beneficiary's CBA. Refer to the "*Medicare Claims Processing Manual*", Chapter 20, 10-2 at **http://www.cms.gov/manuals/downloads/clm104c20.pdf** for instruction for submitting claims for repairs and replacements.

- 50.13 - Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap;
    - The Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period after the payment cap and of medical need for the remainder of the reasonable useful lifetime established for the equipment. This requirement continues to apply under the Medicare

DMEPOS Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a CBA).

- Should a beneficiary travel or temporarily relocate to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.
- The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.

- 50.14 - Purchased Accessories & Supplies for Use With Grandfathered Equipment; and
  - 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, E0310; and
    - Walkers and Related Accessories - E0154, E0156, E0157 and E0158.
  - 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. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. In addition, 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.

- 50.15 - Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge.
  - 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. 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.

Additional Information

If you have any questions, please contact your Medicare Carrier, FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction associated with this CR7401, issued to your Medicare MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2231CP.pdf** on the CMS website.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/** on the CMS website. Click on the "Provider Educational Products and Resources" tab and scroll down to the "Downloads" section.

Quarterly Update to the End-Stage Renal Disease Prospective Payment System (MM7476) (GEN)

MLN Matters® Number: MM7476
Related CR Release Date: July 15, 2011

Related CR Transmittal #: R2255CP

Related Change Request (CR) #: 7476
Effective date s: 10/1/2011-ICD-9 Updates; 1/1/2011-DME Updates
Implementation Date: October 3, 2011

Provider Types Affected
Physicians, providers, and suppliers, including End-Stage Renal Disease (ESRD) facilities and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, submitting claims to Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs), or A/B MACs for ESRD supplies and services provided to Medicare beneficiaries are affected by this article.

Provider Action Needed
This article, based on Change Request (CR) 7476, advises you about the following corrections to Attachment 4 and Attachment 5 provided in CR7064:

- Removes equipment and supply codes from Attachment 4 that are not separately payable to DMEPOS suppliers, and
- Adds these removed codes to Attachment 5.

You are also advised of the update to Attachment 8 provided with CR7064, which is the list of ICD-9-CM codes eligible for the ESRD Prospective Payment System (PPS) co-morbidity payment adjustment. The list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective January 1, 2011 and the list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 is available at **http://www.cms.gov/ESRDPayment/40_Comorbidity_Conditions.asp#TopOfPage** on the Centers for Medicare & Medicaid Services (CMS) website.

The revised attachments 4 and 5 are attached to CR7476 at **http://www.cms.gov/Transmittals/downloads/R2255CP.pdf** on the CMS website. Items and services that are subject to the ESRD PPS consolidated billing requirements can be found at **http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage** on the CMS website.

Please be sure to inform your staffs of these changes.

Background
MM7064, entitled "End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services," advised you about the implementation of a new bundled payment system for renal dialysis items and services provided on and after January 1, 2011. You may review this article by going to **http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf** on the CMS website.

The ESRD PPS provides payment adjustments for six categories (three acute and three chronic) of co-morbid conditions. When applicable, ESRD facilities can report specific ICD-9-CM diagnosis codes on ESRD facility claims to be eligible for a co-morbidity payment adjustment. The ICD-9-CM codes are updated annually and are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems and are effective each October 1. CR7476 provides updates to attachment 8 of CR7064, which includes the ICD-9-CM codes eligible for the ESRD PPS co-morbidity payment adjustment in accordance with the annual ICD-9-CM update, which is effective October 1, 2011.

Changes to the ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 include:

1. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.41 - Sickle-cell thalassemia without crisis has been revised to include microdrepanocytosis.
2. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, the 5 new ICD-9 codes added are as follows:
    - **282.43 Alpha thalassemia**
        - Alpha thalassemia major
        - Hemoglobin H Constant Spring
        - Hemoglobin H disease
        - Hydrops fetalis due to alpha thalassemia

- Severe alpha thalassemia
- Triple gene defect alpha thalassemia
- **Excludes:** alpha thalassemia trait or minor (282.46); hydrops fetalis due o isoimmunization (773.3); hydrops fetalis not due to immune hemolysis (778.0)

- **282.44 Beta thalassemia**
  - Beta thalassemia major
  - Cooley's anemia
  - Homozygous beta thalassemia
  - Severe beta thalassemia
  - Thalassemia intermedia
  - Thalassemia major
  - **Excludes:** beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); hemoglobin E beta thalassemia (282.47); sickle-cell beta thalassemia (282.41, 282.42)

- **282.45 Delta-beta thalassemia**
  - Homozygous delta-beta thalassemia
  - **Excludes:** delta-beta thalassemia trait (282.46)

- **282.46 Thalasesmia minor**
  - Alpha thalassemia minor
  - Alpha thalassemia trait
  - Alpha thalassemia silent carrier
  - Beta thalassemia minor
  - Beta thalassemia trait
  - Delta-beta thalassemia trait
  - Thalassemia trait NOS
  - **Excludes:** alpha thalassemia (282.43); beta thalassemia (282.44); delta beta thalassemia (282.45); hemoglobin E-beta thalassemia (282.47); sickle-cell trait (282.5)

- **282.47 Hemoglobin E-beta thalassemia**
  - Excludes: beta thalassemia (282.44); beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); delta-beta thalassemia trait (282.46); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle-cell beta thalassemia (282.41, 282.42)

3. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 - Other thalassemia has been revised to no longer include Cooley's anemia, Hb-Bart's disease, Microdrepanocytosis, Thalassemia (alpha) (beta) (intermedia) (major) (minima) (minor) (mixed) (trait), and Thalassemia NOS.

4. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 - Other thalassemia has been revised to include Dominant thalassemia, Hemoglobin C thalassemia, Mixed thalassemia, and continues to include Thalassemia with other hemoglobinopathy.

5. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 - Other thalassemia has been revised to exclude hemoglobin C disease (282.7); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle cell anemias (282.60-282.69); and sickle-cell beta thalassemia (282.41-282.42)

Attachment 4 of CR7064, DME ESRD Supply Healthcare Common Procedure Coding System (HCPCS) for ESRD PPS Consolidated Billing Edits, included the list of equipment and supplies that are ESRD-related but can be used in other provider settings for reasons other than for the treatment of ESRD. Attachment 5 of CR7064, DME ESRD Supply HCPCS Not Payable to DME Suppliers, included the list of the DME ESRD supply codes that are no longer separately payable to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers. To allow DMEPOS suppliers to get paid for furnishing these services under other circumstances covered by Medicare, CR7064 provided instructions stating that DMEPOS suppliers may bill the items listed on Attachment 4 with the AY modifier to indicate that the item is used for reasons other than for the treatment of ESRD. Currently, there are equipment and supplies listed on Attachment 4 that are not used in other provider settings and would therefore never be used for reasons other than for the treatment of ESRD. Therefore, these items would not be covered by Medicare because there is no other benefit category that can provide coverage. CR7476 rescinds and replaces Attachments 4 and 5 of CR7064 as follows: Removes equipment and supply codes

from Attachment 4 that are either not separately payable or not payable by Medicare and add these codes to Attachment 5. Surgical dressing code A6204 will also be included in Attachment 5.

Additional Information
The official instruction, CR7476, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R2255CP.pdf** on the CMS website.

If you have any questions, please contact your 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.

Recovery Audit Program: Medicare Administrative Contractor (MAC)-issued Demand Letters (MM7436) (GEN)

MLN Matters® Number: MM7436
Related CR Release Date: July 29, 2011
Related CR Transmittal #: R192FM

Related Change Request (CR) #: 7436
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected
This article is for all physicians, providers, and suppliers who bill Medicare claims processing contractors (Carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (MACs)).

Provider Action Needed
Impact to You
This article is based on Change Request (CR) 7436 which announces that Medicare's Recovery Auditors will no longer issue demand letters to you as of January 3, 2012.

What You Need to Know
Recovery Auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the Recovery Auditor's review, and issue an automated demand letter to you.

What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its Recovery Auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a Recovery Auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any Recovery Auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating Recovery Auditor and his/her contact information in the related demand letter. You should contact that Recovery Auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.

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. To see the official instruction (CR7436) issued to your Medicare contractor, see **http://www.cms.gov/Transmittals/downloads/R192FM.pdf** on the CMS website.

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

MLN Matters® Number: MM7499
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R940OTN

Related Change Request (CR) #: CR 7499
Effective Date: January 1, 2012
Implementation Date: April 2, 2012

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

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

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

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

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

CR7499 instructs the shared systems to replace the HIC number being sent on the ERA with the Patient Control Number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

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

Additional Information
The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R940OTN.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.

CMS News Flash (GEN)

A new publication titled "*Comprehensive Error Rate Testing (CERT) - Evaluation and Management (E/M) Services: Overview*" is now available in downloadable format from the Medicare Learning Network® at **http://www.CMS.gov/MLNProducts/downloads/Evaluation_Management_Fact_Sheet_ICN905363.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. This fact sheet is designed to provide education on Evaluation and Management Services to Medicare Fee-For-Service providers, and includes information on the documentation needed to support a claim submitted to Medicare for medical services.

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

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

Is your organization preparing for a smooth transition to ICD-10 on October 1, 2013? The Centers for Medicare & Medicaid Services (CMS) ICD-10 website at **http://www.cms.gov/icd10** is a valuable resource to help you prepare for the U.S. healthcare industry's change from ICD-9 to ICD-10 for medical diagnosis and inpatient procedure coding. Check back frequently for the latest news, resources, compliance timelines, and teleconference information. While you are visiting the site, sign up for the CMS ICD-10 Industry Email Updates to receive the latest information on the transition and new website content.

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.

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

The "*World of Medicare*" Web-Based Training (WBT) course has been revised (as of January 2011). It is designed for healthcare professionals who want to understand the fundamentals of the Medicare program, and covers Medicare Part A, Part B, Part C, and Part D; identifying Medicare beneficiary health insurance options; eligibility and enrollment; as well as recognizing how Medigap and Medicaid work with the Medicare program. This WBT course offers continuing education credits; please see the course description for details. To access the training course, visit **http://www.CMS.gov/MLNGenInfo** on the Centers for Medicare & Medicaid Services (CMS) website, scroll to "Related Links Inside CMS," select "Web-Based Training (WBT) Modules," and then select "World of Medicare (Developed: January 2010 / Revised January 2011)" from the list of trainings provided.

The Centers for Medicare & Medicaid Services (CMS) has posted 18 new FAQs about HIPAA version 5010 implementation, and one PDF document containing 27 Q&As specific to the Wednesday, March 30, CMS-hosted 5010 national provider teleconference on provider testing and readiness. To review these FAQs, visit the CMS FAQ database at http://questions.CMS.hhs.gov and search for "5010." For more information, you can also go to **http://www.cms.gov/Versions5010andD0/downloads/033011_National_Call_Resource_Mailbox_Qs_and_As.pdf** on the CMS website.

Did you know that Medicare provider enrollment application forms can be completed on your computer? This means that you can fill out the information required by typing into the open fields while the form is displayed on your computer monitor. Filling out the forms this way before printing, signing, and mailing means more easily-readable information - which means fewer mistakes, questions, and delays when your application is processed. Be sure to make a copy of the signed form for your records before mailing. You can find the Medicare provider enrollment application forms at **http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and the National Council for Prescription Drug Program's (NCPDP) version D.0 standards as of January 1, 2012. To facilitate the implementation, Medicare has designated Calendar Year 2011 as the official 5010/D.0 transition year. As such, Medicare Administrative Contractors (MACs) will be testing with their trading partners throughout Calendar Year 2011. Medicare encourages its providers, vendors, clearinghouses, and billing services to schedule testing with their local MAC as soon as possible. CMS 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 July 2011 issue of the "*Medicare Quarterly Provider Compliance Newsletter*" is now available in downloadable format from the Medicare Learning Network® at **http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903687.pdf** on the Centers for Medicare & Medicaid Services (CMS) website. This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. Please visit **http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf** to download, print, and search newsletters from previous quarters.

The Version 5010 compliance date - January 1, 2012 - is fast approaching. Are you prepared for the transition? Medicare Fee-for-Service (FFS) trading partners are encouraged to contact their Medicare Administrative Contractors (MACs) now and facilitate testing to gain a better understanding of MAC testing protocols and the transition to Version 5010. To assist in this effort, the Centers for Medicare & Medicaid Services (CMS), in conjunction with the Medicare FFS Program, announce a National 5010 Testing Week to be held August 22 through August 26, 2011. National 5010 Testing Week is an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs. For more information on Version 5010, please visit the CMS dedicated 5010 website at **http://www.CMS.gov/Versions5010andD0** on the CMS website.

The publication titled "*How to Search the Medicare Coverage Database*" (revised April 2011), is now available in downloadable format from the Medicare Learning Network®. It was designed to provide education about how to use the Medicare Coverage Database (MCD) and includes an explanation of the database and how to use the search, indexes and reports, and download features. The booklet is available at **http://www.cms.gov/MLNProducts/downloads/MedicareCvrgeDatabase_ICN901346.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

"*Your Office in the World of Medicare*" Web-Based Training (WBT) course has been revised (as of February 2011). It is designed to provide education on the fundamentals of the Medicare Program, and includes information about Parts A, B, C, and D; beneficiary health insurance options; eligibility and enrollment; and how Medigap and Medicaid work with the Medicare Program. This WBT course offers continuing education credits; please see the course description for details. To access the training course, visit **http://www.CMS.gov/MLNGenInfo** on the Centers for Medicare & Medicaid Services (CMS) website, scroll to "Related Links Inside

CMS," select "Web-Based Training (WBT) Modules," and then select "Your Office in the World of Medicare (Developed: January 2010 / Revised February 2011)" from the list of trainings provided.

Several fact sheets that provide education to specific provider types on how to enroll in the Medicare Program and maintain their enrollment information using Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) have been recently updated and are available in downloadable format from the Medicare Learning Network® (MLN). Please visit **http://www.CMS.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf** for a complete list of all MLN products related to Medicare provider-supplier enrollment.

The "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards*" fact sheet is now available in a hard copy format from the Medicare Learning Network. This fact sheet is designed to provide education on DMEPOS quality standards for Medicare-deemed Accreditation Organizations (AOs) for DMEPOS suppliers. To place your order, visit the MLN Product Ordering Page at **http://CMS.meridianksi.com/kc/pfs/pfs_lnkfrm_fl.asp?lgnfrm=reqprod&function=pfs** on the Internet.

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.

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

LCDs can also be found on the CMS Web site within the Medicare Coverage Database (MCD), which is accessible by going to: **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx**

Billing Reminder - Billing for Supplies Prior To Delivery of the Base Item

Supplies are a loosely defined category of items that are used with base items of DME. They are either consumed (used up) or require frequent replacement. Many DME items require supplies be used in conjunction for the base item to be functional. Some examples (not all-inclusive) are strips and lancets used with home glucose monitors or the drugs used with infusion pumps and nebulizers.

Payment for supplies is contingent upon the coverage of the base DME item. If the DME item is covered (meets all applicable payment requirements) then supplies used with that item are also covered. Supplies sometimes have specific coverage criteria that must be met in addition to the base item before payment can be made.

No payment may be made for supplies that are billed with dates of service (DOS) prior to the initial DOS of the base item associated with the supplies. Supplies billed with a DOS before the initial DOS of the base item will be denied as statutorily noncovered (no benefit). Suppliers are encouraged to assure that the base item is delivered on or before the delivery date of any supplies in order to avoid unnecessary denials. Sometimes multiple suppliers may be involved as in the case of nebulizers and associated drugs. This may require close coordination between all parties to avoid needless denials.

For appeals, suppliers are reminded that it is necessary to provide information from the medical record demonstrating that the coverage criteria for all items were met and that the base item was ordered, along with any supplies, prior to the DOS of the denied supplies.

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

Drugs Used With External Infusion Pumps - Coverage and Billing Reminders (DRU)

Coverage of drugs used with external infusion pumps may have differing denials. It is important for suppliers of these drugs to understand the issues related to coverage and denials. Understanding coverage necessarily starts with a discussion of benefit category. Fee-for-Service Medicare is a defined benefit program. Without a statutorily defined benefit, there can be no reimbursement from Medicare. External infusion pumps are covered under the DME benefit; however, there is no separate, specific benefit established for the payment of drugs used in external infusion pumps. Drugs used in conjunction with a covered pump are considered a supply item for the pump and are eligible for reimbursement only on that basis. This means that all infusion drug claims not associated with an external infusion pump will receive a statutorily noncovered denial.

Coverage must also take into consideration the applicable reasonable and necessary (R&N) criteria (also known as medical necessity criteria). National and Local Coverage Determinations (NCD and LCD) contain the R&N rules that are applicable to pumps and infusion drugs. For external infusion pumps, the LCD lists the only covered drugs. For many of the drugs, additional specific R&N criteria also apply. Reimbursement for the pump and drug is possible only when a listed drug is provided to a beneficiary meeting all the criteria specified in the LCD. Failure to meet these criteria results in a not reasonable and necessary denial.

Four possible scenarios can result when billing the DME MAC for drugs used with an external infusion pump:

1. Billing for an infusion drug alone (no pump being used). There is no statutory infusion drug benefit to allow coverage. All infusion drugs and any associated supplies will be denied as statutorily noncovered.

2. Billing for a pump with an infusion drug not listed in the LCD. The pump is eligible for coverage under the DME benefit, but because the drug is not listed in the LCD, all items (the pump, drug, and any associated supplies) will be denied as not reasonable and necessary.
3. Billing for a pump with a drug listed in the LCD but the R&N criteria for the drug are not met. The pump, drug, and any associated supplies will be denied as not reasonable and necessary.
4. Billing for a pump with a drug listed in the LCD where the R&N criteria for the drug are met. The pump, drug and any associated supplies are payable if other conditions of coverage are met.

Billing Instructions - ABNs and Modifiers
When the beneficiary does not meet the R&N criteria in an LCD, if the supplier elects to hold the beneficiary financially liable, suppliers may execute an Advance Beneficiary Notice of Noncoverage (ABN) for all items addressed by the policy. Refer to the *Supplier Manual* for additional information on the use of ABNs.

There are several modifiers associated with the billing of external infusion pumps, infusion drugs, and associated supplies. Each modifier has specific associated usage criteria that are discussed in the *Documentation Requirements* section of the LCD. Incorrect or inappropriate application of modifiers can result in claim denials or improper assignment of liability. For items addressed by the External Infusion Pump LCD, the modifiers are:

EY - *No physician or other licensed health care provider order for this item or service.* Use this modifier when the supplier does not have a compliant detailed written order. Use of an EY modifier in this LCD results in an R&N denial.

GA - *Waiver of liability statement issued as required by payer policy, individual case.* Use this modifier when the R&N criteria in the LCD are not met, i.e. scenarios 2 & 3 above, and the supplier elected to obtain an ABN. Use of a GA modifier results in an R&N denial with beneficiary liability.

GY - *Item or service statutorily excluded or does not meet the definition of any Medicare benefit.* Use this modifier for items that fall into scenario 1 above. There items receive a statutory denial with beneficiary liability. An ABN is not required in order to hold the beneficiary financially liable; however, it may be used as a voluntary notice.

GZ - *Item or service expected to be denied as not reasonable and necessary.* Use this modifier when the R&N criteria in the LCD are not met, i.e. scenarios 2 & 3 above, and the supplier elected not to obtain an ABN. Use of a GZ modifier results in an R&N denial with supplier liability.

KX - *Requirements specified in the medical policy have been met.* In this LCD, this modifier is used only with external insulin pumps and supplies. Use this modifier when the R&N criteria in the LCD are met, i.e. scenario 4 above. Use of the KX modifier results in payment for the items addressed in this LCD.

JB - *Administered Subcutaneously.* In this LCD, this modifier is used with immune globulins used for the treatment of primary immune deficiency administered with an external pump (E0779) via the subcutaneous route. Immune globulins not administered subcutaneously must meet the criteria in the Intravenous Immune Globulin LCD.

Vancomycin
Vancomycin does not require the use of a covered external infusion pump for administration. As discussed above, the type of denial associated with claims for vancomycin depends on whether or not an external infusion pump is billed with the drug. Scenarios 1 and 2 above apply to vancomycin:

- If vancomycin is billed without a covered pump, a statutorily noncovered denial will be applied as described in scenario 1. A GY modifier is used.
- If vancomycin is billed with a covered pump, the pump, all associated supplies, and the vancomycin will be denied as not R&N as described by scenario 2. The GA or GZ modifier is used depending upon whether an ABN is executed. Use of the GY modifier is incorrect.

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

Gammagard Liquid® (J1569) Added as Covered Subcutaneous Immune Globulin (DRU)

Gammagard Liquid® (J1569) is added to the External Infusion Pump LCD as covered subcutaneous immune globulin effective for dates of service on or after July 22, 2011.

The existing HCPCS code for Gammagard Liquid® must be used:

> J1569 - INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NONLYOPHILIZED, (E.G. LIQUID), 500 MG

For J1569 and associated infusion pump (E0779) claims where the route of administration is subcutaneous, a JB modifier must be added to each HCPCS code. For other methods of administration, no modifier should be added.

One (1) unit of service (UOS) is 500mg. Gammagard liquid is distributed in multiple package sizes from one (1)-gram (1000mg) to thirty (30)-grams (30,000mg). Suppliers must choose the package size that is appropriate for the dosage being administered to minimize waste. For example,

> 1500mg is prescribed (3 UOS). Gammagard liquid is available in 1-gram (2UOS) and 2.5-gram (5 UOS) sizes. Two 1-gram vials (4 UOS) must be used rather than one 2.5-gram vial (5 UOS).

Excess wastage due to non-optimal vial sizes will be denied as not reasonable and necessary.

As a reminder, below are the coverage criteria from the External Infusion Pump LCD:

> "Subcutaneous immune globulin (J1559, J1561, J1562) is covered only if criteria 1 and 2 are met:
> 1. The subcutaneous immune globulin preparation is a pooled plasma derivative which is approved for the treatment of primary immune deficiency disease; and
> 2. The patient has a diagnosis of primary immune deficiency disease (ICD-9 codes 279.04, 279.05, 279.06, 279.12, 279.2).
>
> Coverage of subcutaneous immune globulin applies only to those products that are specifically labeled as subcutaneous administration products. Intravenous immune globulin products are not covered under this LCD.
>
> Only an E0779 infusion pump is covered for the administration of subcutaneous immune globulin. If a different pump is used, it will be denied as not reasonable and necessary."

Gammagard Liquid will be added in a future revision of the LCD.

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

Items Provided on a Recurring Basis and Request for Refill Requirements (GEN)

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. CMS has revised the requirements for refills effective for dates of service on or after August 02, 2011.

Requirements
For all DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use.

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the

refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a one- or three-month quantity at a time. See below for billing frequencies.

Documentation Requirements
A routine refill prescription is not needed. A new prescription is needed when:

- There is a change of supplier
- There is a change in treating physician
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires

For items that the patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Quantity of each item that the beneficiary still has remaining

This information must be kept on file and be available upon request.

Billing Frequencies
For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, external infusion pump drugs and supplies, and oral antiemetic drugs, only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis, including but not limited to DME accessories or supplies, nebulizer drugs, urological and ostomy supplies, suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous
The Local Coverage Determinations affected by these requirements will be updated in a future revision. The following policies are subject to these requirements:

- Automatic External Defibrillators
- Enteral Nutrition
- External Infusion Pumps
- Glucose Monitors
- Immunosuppressive Drugs
- Intravenous Immune Globulin
- Nebulizers
- Negative Pressure Wound Therapy
- Oral Anticancer Drugs

- Oral Antiemetic Drugs
- Ostomy Supplies
- Oxygen (for billable contents)
- Parenteral Nutrition
- Positive Airway Pressure Devices
- Respiratory Assist Devices
- Suction Pumps
- Surgical Dressings
- Tracheostomy Supplies
- Transcutaneous Electrical Nerve Stimulator (TENS)
- Urologic Supplies

These requirements are not limited to DMEPOS refills for items addressed in LCDs only. All DMEPOS items that are refilled on a recurring basis are subject to these requirements.

This article replaces the articles "*Request for Refill - Documentation Requirements," published in September 2010 and "Dispensing DMEPOS Items: Quantity Limits*" published in June 2007.

For additional information, refer to CMS' *Program Integrity Manual*, Internet-Only Manual, and CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6, the applicable Local Coverage Determination and the *Supplier Manual*.

LCD and Policy Article Revisions - Summary for August 25, 2011 (GEN)

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

Glucose Monitors

LCD

Revision Effective Date: 08/02/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Refills information

DOCUMENTATION SECTION:

Added: Refills documentation information

Nebulizers

LCD

Revision Effective Date: 08/02/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Refills information

DOCUMENTATION SECTION:

Added: Refills documentation information

Deleted: Statement requiring routine prescription every 12 months.

Policy Article

Revision Effective Date: 08/02/2011

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Noncoverage statement for drugs not administered through DME

Added: Noncoverage statement for disposable equipment

Negative Pressure Wound Therapy Pumps

LCD

Revision Effective Date: 10/01/2011

INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:

- Added: Definition for NPWT systems and wound suction systems
- Revised: A6550 quantities statement to be consistent with the HCPCS narrative all-inclusive definition
- Revised: Untreated osteomyelitis exclusion
- Added: Reference statement for wound suction pumps and associated dressings pointing to Suction Pump LCD.
- Revised: Supplies refill monitoring and dispensing instructions. (Effective 08/02/2011)

DOCUMENTATION REQUIREMENTS:

- Revised: Preamble
- Added: Statement about comparison of wound measurements
- Added: Statement about initial inpatient start date.
- Added: Statement about documentation for treatment past the initial 4-months
- Revised: Length of need for the prescription
- Revised: Appeals information for extended months of treatment
- Added: Refill Documentation guidelines. (Effective 08/02/2011)

Policy Article

Revision Effective Date: 10/01/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added: Noncoverage statement for disposable items

CODING GUIDELINES:

- Added: System statements for NPWT
- Added coding instructions for nondurable (disposable) pumps and related supplies
- Clarified: A6550 as dressing allowance.

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 10/01/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Added: PSG and HST testing guidance.
- Added: CR7452 refill requirements (effective 08/02/2011)

HCPCS CODES AND MODIFIERS:

- Added: Q0 modifier

DOCUMENTATION REQUIREMENTS:

- Revised: Prescription requirements
- Clarified: Documentation requirements form NCD 240.2 and PIM Ch. 5
- Added: CR7452 refill requirements effective (08/02/2011)
- Added: Cluster Headache section

Policy Article

Revision Effective Date: 10/01/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added: CR7213 reasonable useful lifetime provisions (effective 05/08/2011)
- Added: Reference to CR7452 refill requirements LCD provision to oxygen contents (effective 08/02/2011)

CODING GUIDELINES:

- Added: Cluster headache oxygen contents coding instruction

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

LCD

Revision Effective Date: 08/02/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Revised: Refills information

DOCUMENTATION SECTION:

Added: Refills documentation information

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

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

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

Wheelchair Options and Accessories

LCD

Revision Effective Date: June 1, 2011

DOCUMENTATION REQUIREMENTS:

Revised: Language for detailed product description.

Wheelchair Seating

LCD

Revision Effective Date: June 1, 2011

DOCUMENTATION REQUIREMENTS:

Revised: Language for detailed product description.

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

LCD Revisions Released for Comment - Automatic External Defibrillators, Pneumatic Compression Devices, and Suction Pumps (GEN)

Dear Physician, Supplier, Specialty Group:

The Centers for Medicare and Medicaid Services (CMS) assigned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for processing and reviewing Medicare claims for Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS). The DME MACs are proposing revisions to three LCDs: **Automatic External Defibrillators, Pneumatic Compression Devices, and Suction Pumps**.

These three LCDs are revisions to existing LCDs; therefore not all of the material in each policy is new. The major revisions are summarized below; however, each LCD should be completely reviewed in the preparation of comments.

Automatic External Defibrillator LCD changes

- Revised coverage criteria for wearable (K0606) and non-wearable (E0617) defibrillators
- Added definition for myocardial infarction to maintain consistency with national coverage determination for implantable defibrillators
- Revised covered diagnosis code list

Pneumatic Compression Devices (PCD) LCD changes

- Added coverage for peripheral arterial disease using arterial insufficiency devices (E0675)
- Revised coverage criteria for PCDs E0650, E0651 and E0652

Suction Pumps LCD changes

- Added not reasonable and necessary statement for wound suction pumps (K0743) and related supplies (K0744-K0746)
- Added coverage criteria for gastric suction (E2000)

We are soliciting comments on these draft policies from physicians, manufacturers, suppliers and other professionals involved in the ordering or provision of these items. We recommend that you distribute these draft policies to selected members of your organization for review and comment. If you disagree with any aspect of a policy, you should be very specific in your comment and, if possible, offer an alternative. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). We encourage a written response if you agree with this policy. **If you are providing comments on more than one LCD, please provide separate comments for each policy with the policy indicated in the subject line of the submission.**

All comments will be collected at a single point of contact. **Please submit your comments electronically to the DME MAC medical directors at the e-mail address below no later than September 23, 2011.** Comments may also be submitted hardcopy although e-mail is preferred.

Paul J. Hughes, MD
Medical Director, DME MAC, Jurisdiction A
NHIC, Corp.
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Hingham, MA 02043
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A joint DME MAC public meeting will be held on August 30, 2011 in Baltimore, MD. Interested parties from any DME MAC jurisdiction may attend this public meeting. This meeting is for oral presentations only. Meeting minutes are not taken and there is no Question and Answer component to the meeting. In order for comments to be considered, they must be presented in writing through the formal comment process. Advance registration is required. Information regarding this meeting will be posted in the near future on each DME MAC web site.

IMPORTANT REMINDER Suppliers are cautioned not to make any changes based upon the information contained in these draft documents. Drafts are often substantially revised based upon the comments received. When all comments have been reviewed, revisions will be considered. The final policies will be published in the CMS Medicare Coverage Database and on individual DME MAC web sites, allowing for adequate notice before the policies' effective date.

Thank you for your participation in our policy revision process.

Refer to each DME MAC web site for additional information about policy development and copies of the draft LCDs.

Jurisdiction A - **http://www.medicarenhic.com**
Jurisdiction B - **http://www.ngsmedicare.com**
Jurisdiction C - **http://www.cgsmedicare.com/jc**
Jurisdiction D - **http://www.noridianmedicare.com/dme**

New K-Codes for Wound Suction Pumps and Associated Dressings - Coding Guidelines (SPE)

New HCPCS codes have been created to describe wound suction pumps and the dressing sets associated with them. These new K-codes are effective for claims with dates of service on or after July 01, 2011. The new codes are:

K0743 - SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS

K0744 - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS

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

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

Wound suction is provided with an integrated system of components. This system contains a pump (K0743) and dressing sets (K0744 - K0746). It does not include a separate collection canister (A7000), a defining component of Negative Pressure Wound Therapy (NPWT). Instead, exudate is retained in the dressing materials. Therefore, wound suction systems are not classified as NPWT systems. These codes will be added to the *Suction Pump LCD* in a future revision to that policy.

Systems that do not contain all of the required components are not classified as wound suction systems. See below for component specifications

Code K0743 describes a suction pump for wounds which provides controlled subatmospheric pressure that is designed for use with dressings (K0744 - K0746) without a canister.

Codes K0744 - K0746 describe an allowance for dressing sets that are used in conjunction with a stationary or portable suction pump (K0743) but not used with a canister. Each of these codes (K0744 - K0746) is used for a single, complete dressing change, and contains all necessary components, including but not limited to non-adherent porous dressing, drainage tubing, and an occlusive dressing which creates a seal around the wound site for maintaining subatmospheric pressure at the wound. These dressing sets are selected based upon wound size using the smallest size necessary to cover the wound. For multiple wounds located close together, a single large dressing must be used rather than multiple smaller dressing sets if it is possible to fit the wounds under a single larger dressing set.

Disposable wound suction system pumps must be coded A9270 (Noncovered item or service).

Supplies, including dressings, used with disposable wound suction systems must be coded as A9270 (Noncovered item or service).

Only products reviewed by the PDAC and placed on the product category list may use the NPWT codes E2402 and A6550.

Power Wheelchair Rental - Frequently Asked Questions - UPDATED June 2011 (MOB)

Effective for items provided on or after January 1, 2011, standard power wheelchairs (K0813 - K0831, K0898) must be furnished on a monthly rental basis like other capped rental durable medical equipment (DME). The following are questions and answers from suppliers regarding application of the Power Mobility Devices medical policy and CMS payment policy rules to rented power wheelchairs.

Short-term use

1. When standard power wheelchairs (PWCs) are provided on a rental basis, can they be covered for short-term indications?

   Response: No. The change in the payment policy status for PWC does not change the policy statement that PWCs are not covered for patients with short term, reversible conditions.

2. A short-term rental would occur if the beneficiary were to pass away in the second month of the rental period. Will a short duration in billing signal that a short-term rental has occurred and flag the claim for review?

   Response: If all the criteria are met for coverage of a PWC and the initial rental months are paid but the beneficiary dies within the first 3 months or the patient goes into a nursing home on a permanent basis during the first 3 months, that does not affect coverage of those initially paid rental months.

Change of residence

3. Is it advisable for the supplier to document in their records that they have contacted the beneficiary and confirmed that the beneficiary is able to use the PWC they are renting in their new residence?

Response: There is no requirement for a supplier to reassess the home in the event that a beneficiary changes residence.

4. If the new residence will not accommodate the PWC the beneficiary is currently renting and a different base (same HCPCS code) is required will the supplier need to obtain a new detailed product description for the item that can be used in the home?

Response: Medicare would not start a new-capped rental period in this situation. If the supplier elects to provide a different wheelchair base (different HCPCS code), a new signed and dated detailed product description is needed but a new face-to-face examination or 7-element order is not needed.

5. If a patient with a PWC moves and their new home will no longer accommodate the PWC that they have, will Medicare pay for a new PWC?

Response: No. Medicare covers a replacement only if an item is lost, stolen, irreparably damaged, or reaches the 5 year reasonable useful lifetime. Medicare covers a different item only if there is a change in the beneficiary's medical condition.

Break in service

6. A PWC is being rented and the beneficiary goes into a hospital and nursing home for an extended stay. The supplier elects to pick up the wheelchair. When the beneficiary is ready to go back home, would there be a problem with providing a different model wheelchair within the same HCPCS code?

Response: If the supplier chooses to deliver a different model of PWC within the same code, a new detailed product description must be obtained. A new face-to-face (FTF) examination or 7-element order is not needed.

7. If a patient who is renting a PWC goes into a hospital/nursing home for an extended time and the supplier picks up the wheelchair and the beneficiary is discharged to home, would a new capped rental period start and what documentation would be required?

Response: Existing capped rental rules for beginning a new rental period apply to power wheelchairs. That policy states that a new capped-rental period will begin only if there has been a break in medical necessity of at least 60 days plus the days remaining in the last paid rental month. In the situation that is described, "medical necessity" would continue while the patient was in a facility. If the patient is receiving the same type of PWC (same code) on discharge that they previously had, then the rental period resumes where it left off and no additional documentation is needed (other than a new detailed product description if the make/model of the wheelchair has changed). If the patient needs a different type of PWC on discharge because of a change in their medical condition, all the requirements for a new PWC must be met (i.e., FTF exam, 7-element order, etc.).

8. If the beneficiary is renting a PWC coded K0823 prior to entering the hospital, would a new rental episode begin if, while in the hospital, they develop a Stage II decubitus ulcer over the sacrum and upon discharge require a PWC coded K0822 and a skin protection cushion, E2603?

Response: Yes. However, following standard rules, since it is a different item, there would have to be a new face-to-face-examination (which documents the medical necessity for the new item), 7-element order, detailed product description, home assessment, etc.

Repair / Replacement

9. If, during a capped rental period, a PWC is lost, stolen, or irreparably damaged and a new PWC is provided, does a new capped rental period start?

Response: Yes. Replacement of power wheelchairs will follow the same rules as any other rented DME item.

10. Medicare provides for the replacement of lost, stolen, or irreparably damaged items but we are concerned as to how this fits with Supplier Standard # (14), which states: "Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced." Can you please clarify, as this is a significant concern for providers and beneficiaries?

Response: The Supplier Standards address situations related to non-function or damage of an item that can be repaired or to replacement of an item due to wear and tear. Lost, stolen, or irreparably damaged items are a different category.

The *Medicare Benefit Policy Manual*, Chapter 15, Section 110.2(A) states:

> "Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for repair of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental and inexpensive or routinely purchased payment categories which are being rented."
>
> "Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment." (This means that replacement due to wear and tear is possible only after the 5-year reasonable useful lifetime.)

The *Medicare Benefit Policy Manual*, Chapter 15, Section 110.2(C) defines payment policy for items that are lost or that have been irreparably damaged by an acute incident:

> "Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood). "

11. Is there any situation in which a supplier can be paid for repair to a PWC during a capped period - e.g., if the supplier has information to indicate that the repair is required due to "malicious damage" or "culpable neglect" by the beneficiary?

Response: There can be no payment for the repair of rented items under any circumstances. Reimbursement for repairs is included in the rental payments.

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

12. How does a supplier alert the DME MAC that they believe the PWC requires a repair secondary to malicious damage or culpable neglect?

Response: The supplier can notify the Written Inquiries Department for Jurisdiction A in writing.

13. Who is responsible for determining when a beneficiary is responsible for the damage and how will this be communicated?

Response: As discussed in a previous question, the DME MAC will consult with CMS to make that determination. Since these are very rare situations, there is no established procedure. They will be handled on an individual basis.

14. Unique to PWCs is the fact that beneficiaries often use the products outside the home as well as inside. This is generally not done with other capped rental items (e.g., hospital beds never leave the home). If a PWC is damaged outside the home, since that is not an approved use per Medicare, will the supplier be expected to repair the chair "at no charge" during the rental period?

Response: Yes, the supplier is responsible for the repair. Statutory coverage of DME requires that it be needed for use inside the home. However, if that requirement is met, the item may be used outside the home. Portable oxygen, nebulizers, walkers, canes, crutches, POVs, manual and power wheelchairs are among the many item, both rental and purchase, that are routinely used outside of the home setting. During the rental period, the supplier is expected to repair an item if the repair was related to

damage that occurred either inside or outside the home. For purchased and rental items where the title has transferred, repairs are covered under the general repair rules.

15. How would a supplier prove the damage occurred outside the home (unless it is obvious, like sand/mud/water in the motor?

Response: Use of a DME item outside of the home is not deemed evidence of deliberate malicious damage or culpable neglect.

16. If the beneficiary has a PWC under rental and the PWC has a service/repair issue, is it permissible to provide the beneficiary with a loaner manual wheelchair while the PWC is being repaired or is the supplier required to replace the PWC?

Response: The supplier is required to provide a loaner item that meets the beneficiary's medical need.

17. While their rental PWC is being repaired, does monthly billing for the PWC continue?

Response: Yes, monthly billing for the PWC would continue. There should be no separate billing and/or payment for the loaner wheelchair during the 13 month capped rental period.

18. If a replacement power wheelchair of the same HCPCS code is provided, but it is a different manufacturer, make or model than the power wheelchair listed on the detailed product description (DPD) is a new DPD required for billing the months following the replacement.

Response: Replacement of a power mobility device (PMD) at the end of the 5 yr. useful lifetime requires a complete reassessment following the same rules as if a new initial PMD was being provided.

Miscellaneous

19. If the beneficiary weighs 478 pounds and is renting a heavy-duty PWC coded K0827 prior to a hospitalization and/or SNF stay has a significant weight loss taking them below the 300 pounds limit for standard power wheelchairs, would a new rental episode begin upon return to home, for a standard PWC coded K0825?

Response: No. If the patient loses weight, the original wheelchair would still meet the patient's needs. If the supplier elects to provide a lower weight capacity PWC, a new capped-rental period would not begin.

20. How will the "look back" period affect the review of PWCs?

Response: There is a general policy that coverage of items that are provided on an ongoing basis, including rented DME, is dependent on there being continued need for the item and continued use by the beneficiary. CMS and the DME MACs have not published any information regarding the look back period.

21. Will elevating leg rests (already a mandatory capped rental item) be paid at 15% in months 1-3 and 6% in months 4-13 or will they remain at a payment rate of 10% in months 1-3 and 7.5% in months 4-13?

Response: Payment policy for accessories is not changing.

22. If payment for separately billable items at initial issue will be at the front loaded rate how will these items be distinguished as receiving a different payment methodology from the same items (other than batteries) on a PWC?

Response: Payment policy for accessories is not changing.

23. Will a "patient requested upgrade" from a Group 2 power wheelchair (K0822 - K0831) to a Group 3 power wheelchair base (K0848 - K0855) retain the option to purchase the chair in the first month?

Response: No, the application of upgrade provisions does not change the payment rules for any item.

24. Do PMD documentation requirements differ in any way since the elimination of the first month purchase option for beneficiaries living in a zip-coded area outside of a competitive bid area (CBA)?

Response: The documentation requirements do not differ based upon whether the PMD is paid as a rental in a non-CBA or as a purchase in a CBA.

25. Must supplier records document ongoing use of the PMD by the beneficiary during the 13-month rental or is a physician order indicating lifetime use sufficient?

Response: For PMDs that are provided under the rent to purchase guidelines over 13 months, it is expected that the supplier records will substantiate the beneficiary's ongoing use of the PMD for the period for which claims are submitted.

26. Is there a requirement mandating that contact with the beneficiary must be made at certain intervals to determine if a PMD meets the ongoing use requirement?

Response: If a beneficiary discontinues use of a rental DME item, the supplier may not continue to bill Medicare for that item. Although Medicare does not have specific guidelines on how a supplier should monitor and document use, each claim submitted may be subject to review. Supplier records must clearly demonstrate ongoing monitoring and use of the rental item by the beneficiary if audited.

27. If a physician's order documents lifetime medical necessity for a PMD, must the physician's medical record indicate that the patient has been seen during the 13-month period and document that ongoing medical necessity is met?

Response: The PMD policy does not mandate that the treating physician must formally monitor and/or recertify these devices on a scheduled basis. However, each claim may be subject to review to determine whether payment continues to be justified. Thus, some evidence must be present in the medical record demonstrating that the initial qualifying medical condition(s) continues to be present and that the need for the item continues. This may be noted intermittently throughout the course of the rental cycle.

Progressive Corrective Action (PCA) (GEN)

PCA is an operational principle upon which all medical review activities are based. PCA involves data analysis, error detection, validation of errors, provider education, determination of review type, sampling claims and payment recovery. It serves as an approach to performing medical review and assists contractors in deciding how to deploy medical review resources and tools appropriately.

The Medicare Administrative Contractor (MAC) may use any relevant information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or other entity when the contractor deems it necessary and in accordance with our manuals, through a process known as Additional Documentation Request (ADR).

Additional Documentation Request (ADR)
The ADR will include a specific list of the documents the supplier is requested to provide within 30 days from the date of the notification letter. The Medical Review clinician will always need a copy of the written order, shipment or delivery documentation, and any other documentation specified in the LCD for the HCPCS code being reviewed. The supplier will also be required to send copies of actual medical records (not just supplier forms, physician attestations, etc.) that support the medical necessity for the item(s) being reviewed.

Suppliers are reminded that other Medicare contractors often develop claims for additional records. It is therefore very important for suppliers to read any Medicare correspondence thoroughly and carefully follow the instructions for submitting copies of the requested documents.

If the 30 day response time frame is nearing and only a partial response is available, please wait to respond until you have all the required documents if you expect to have them within a few days. This is the recommended practice, rather than submitting a partial response, receiving a denial and then submitting a redetermination request with the remaining information.

If your response is received within a reasonable time frame after your claim has denied for lack of response, it can be reopened and reviewed.

Per the *Medicare Program Integrity Manual* (Pub 100-08), Chapter 3, section 3.2.3.9 - Reopening Claims with Additional Information or Denied due to Late or No Submission of Requested Information:

> *(Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)*
>
> *If the MACs and CERT receive the requested information from a provider or supplier after a denial has been issued but within a reasonable number of days (generally 15 calendar days after the denial date), they have the discretion to reopen the claim.*

Review Results

Medical Review will publish an educational result article after completion of a widespread review (service or code specific) or send a written summary of findings in a letter directly to the supplier after completion of a targeted review (supplier specific). This summary will explain the reviewer's decisions, cite the Medicare policies and regulations that the decisions were based on, and offer supplier education. The article or letter will also provide the paid claims error rate, explain how the error rate was calculated and list the corrective actions that NHIC, Corp. DME MAC will take to correct the identified errors if needed. All educational result articles for widespread reviews can be found on the NHIC Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

Corrective Actions

When an error has been validated through Medical Review, the corrective action imposed by the MACs should match the severity of the error. PCA is a means of evaluating the relative risk of the error and assigning appropriate corrective actions.

Whenever a probe review identifies claim errors, supplier education will be one of the corrective actions in Medical Review's error reduction plan. Overpayments will be assessed when errors are identified in postpayment probe reviews and in previously paid claims related to prepayment claim reviews. Other corrective actions may include requiring a supplier to submit a corrective action plan, initiating prepayment claim review, expanding reviews to additional HCPCS codes, referral to other Medicare contractors, and payment suspensions. Medical Review implements corrective actions commensurate with the initial error rate and level of concern or severity of errors.

For additional information, please refer to: The *Medicare Program Integrity Manual* Chapter 3 - Verifying Potential Errors and Taking Corrective Actions 3.2 - Overview of Prepayment and Postpayment Reviews **https://www.cms.gov/manuals/downloads/pim83c03.pdf**

Appeal Rights

Suppliers have appeal rights on review claim denials. Appeals must be filed within 120 days of the Remittance Notice date on a prepayment review claim or from the date on the Overpayment Recoupment letter in the case of a postpayment review claim. Refer to the *DME MAC A Supplier Manual* Chapter 8 - Reopenings and Appeals (**http://www.medicarenhic.com/dme/suppmandownload.shtml**) instructions on filing an appeal. Please do not send appeal requests to Medical Review.

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

Historical Review Results
DME MAC A Medical Review continues to review A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Tracheostomy) based on the previous review findings which resulted in a 61% Charge Denial Rate (CDR).

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

The prepayment complex medical review involved 707 claims submitted by 187 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 167 (24%) of the claims. For the remaining 540 claims, 234 claims were allowed and 306 were denied resulting in a claim denial rate of 62.7%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate (CDR) of 51.1%.

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

Medical Necessity Documentation Issues

- 51% of the denied claims were missing any clinical information to support medical necessity. (No medical records of any sort submitted.)
- 23% of the denied claims had insufficient clinical documentation. The medical record information submitted was *insufficient* to show that the coverage criteria listed in the Local Coverage Determination (LCD) were met.

  Examples of insufficient clinical documentation received include:
  - Progress notes without the patient's name
  - Illegible medical records
  - Medical records without any current documentation to show that the patient is still being seen by the physician or other qualified medical professional
  - No mention of patient's diagnosis or use of supplies

Physician Prescription Issues

- 13% of the denied claims had initial dispensing order issues.
  Examples include:
  - No physician prescriptions submitted
  - MD order after the delivery date
  - MD orders were not signed by the prescribing medical provider
  - Outdated orders with expired length of need
  - Unable to verify the treating physician's signature

Proof of Delivery

- 26% of the denied claims had delivery documentation issues.
  Examples include:
  - Missing delivery tickets (no proof that the patient received supplies)
  - Missing supply list (no itemization of what patient received)
  - Missing signature on delivery ticket when delivered directly to the beneficiary (no evidence the supplies were received)

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

Example 1:

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

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

Example 2:

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

Missing: All requested documentation was submitted. However, all of the documentation submitted was for the wrong beneficiary.

Example 3:

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

Missing: The patient's name and date of birth were not listed on the medical records and their name and address was not on the delivery ticket.

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

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

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

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

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

- *Results of Widespread Prepayment Review of Claims for HCPCS Codes A4623 (Tracheostomy, Inner Cannula) and A4629 (Tracheostomy Care Kit for Established Patients)* (Posted on March 21, 2011)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/032111_A4623.pdf

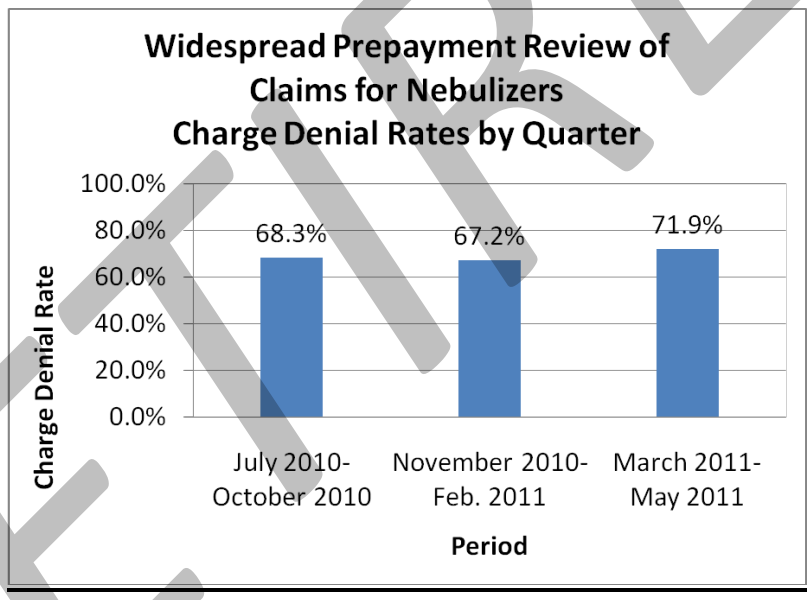
Results of Widespread Prepayment Review for E0570 (Nebulizer, with Compressor) (L11499) (SPE)

Historical Review Results
DME MAC A Medical Review continues to review Nebulizers, with Compressor, based on the results of previous quarterly findings. The previous quarterly findings covered the period of November 2010 through February 2011 and resulted in a 67.2% Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings cover the claim review period from March through May 2011.

The review involved prepayment complex medical review of 684 claims submitted by 403 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 167 (24%) of the claims. For the remaining 517 claims, 139 claims were allowed and 378 were denied resulting in a claim denial rate of 73%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate (CDR) of 71.9%.

Charge Denial Rate Historical Data
The following chart depicts the Charge Denial Rate from previous quarters to current:



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

Clinical Documentation Issues:

- 59% of the denied claims were missing any clinical information to support medical necessity. No medical records of any sort were submitted.
- 10.6% of the denied claims had insufficient clinical documentation. The documentation submitted focused on other medical issues unrelated to nebulizers.
- 7.5% of the denied claims had other clinical documentation issues:
  - Missing signature
  - Clinical records were dated after the date of service
  - Illegible

Detailed Written Order Issues:

- 1% of the denied claims had incomplete detailed written orders due to missing physician signature.
- 1% of the denied claims had incomplete detailed written orders due to an incomplete description.
- 1% of the denied clams had incomplete detailed written orders due to no date on the order.
- 4.3% of the denied claims were missing the detailed written order.
- 5.7% of the denied claims had illegible written orders.

Proof of Delivery Issues:

- 6.4% of the denied claims were missing proof of delivery.
- 1.4% of the denied claims had delivery tickets missing the beneficiary signature.
- 1% of the denied claims had delivery tickets that were dated after the date of service or had multiple tickets submitted.

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

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

Claim Examples:

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

Example 1:

Received: Medical records reflecting reasonable and necessary need for nebulizer equipment
Missing: Proof of delivery with beneficiary signature and date, detailed MD order with legible signature and date.

Example 2:

Received: Claim received with clinical documentation reflecting reasonable and necessary need of nebulizer equipment
Missing: Detailed written order with beneficiary name and legible signature, date of signature.

Example 3:

Received: Detailed written order with beneficiary name and legible signature, date of legible signature and delivery slip with beneficiary signature.
Missing: Supplier did not include any medical records reflecting reasonable and necessary need for nebulizer equipment.

Next Step

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

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

Educational References:

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

- *Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective February 2011 (A24944)*
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

- *Results of Widespread Prepayment Review of Claims for E0570*: posted November 11, 2010 and March 25, 2011
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.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

- *CERT Physician Letter - Nebulizers Monthly CERT Error examples* (January 2011, February 2011 and March 2011)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

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

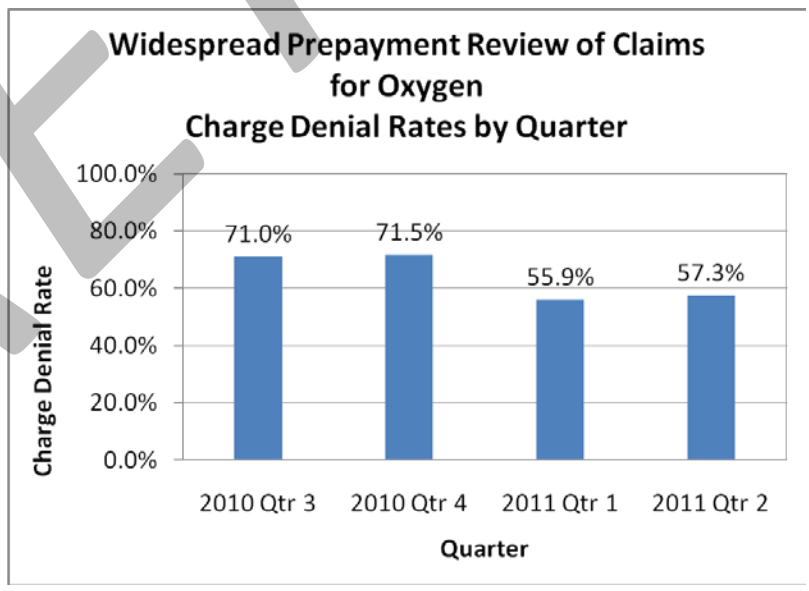
Results of Widespread Prepayment Review for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (OXY)

Historical Review Results
DME MAC A Medical Review continues to review Oxygen and Oxygen Equipment, based on the results of previous quarterly findings. The previous quarterly findings covered the period of January 01, 2011 through March 31, 2011 and resulted in a 55.9% Charge Denial Rate (CDR).

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

The review involved prepayment complex medical review of 1,302 claims submitted by 596 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 348 (27%) of the claims. For the remaining 952 claims, 387 claims were allowed and 567 were denied resulting in a claim denial rate of 59.6%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 57.3%.

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



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

Treating physician visits - Missing documentation: (86.35%)

- 37% of the denied claims were missing treating physician visits - 30 days prior to the Initial CMN (initial issue of oxygen).
- 18.07% of the denied claims were missing treating physician visits - 90 days prior to Recertification CMN (initial issue of oxygen).
- 31.28% of the denied claims were missing ongoing physician documentation for continued need for home oxygen therapy (usually related to 5 year replacement equipment).

Clinical documentation issues: Medical necessity could not be established (10.1%)

- 7.9% of the denied claims did not have documentation validating the oxygen saturation level listed on CMN.
- 1.10% of the denied claims had inconsistent documentation.
    - Initial CMN dated 4/23/08, delivery ticket dated in 2007 and physician written order dated in 2007
    - Delivery ticket is dated in 2007 with an initial CMN dated in 2009. Missing is supporting documentation for a 2007 MD visit. Medical documentation received is not within the 2009 or 2010 initial and recertification guidelines.
- Less than 1% (0.17%) of the denied claims had Nocturnal testing documentation that did not meet Group I criteria guideline (5 minutes 88% or less).
- Less than 1% (0.88%) of the denied claims had incorrect form types such as:
    - No recertification CMN received
    - Revised CMN received when not required, no initial CMN received
    - Revised CMN and Recertification CMN received, no initial CMN received

Billing and Miscellaneous Issues - 3.52%

- 1.10% of the claims involved a supplier billing error:
    - Documentation states billed in error
    - Documentation states patient did not receive equipment
    - No proof of delivery
- 1.10% of the claims involved duplicate submission
- Less than 1% (0.7%) of the denied claims involved a returned ADR with a request for an extension.
- Less than 1% (0.17%) of the denied claims returned the ADR itself, but attached no documentation.
- Less than 1% (0.17%) of the denied claims was beyond the 36 month rental timeframe.

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

Example 1: E0431

Documentation Received: supplier cover sheet, verbal order dated 3/18/11, written order dated 3/18/11, complete Initial CMN dated 3/18/11, testing results of oxygen dated 3/18/11, valid delivery ticket including beneficiary authorization, supplier orientation check sheet.
Missing: physician clinical documentation within 30 days prior to initial CMN.

Example 2: E1390

Documentation Received: nocturnal testing order and physician signature attestation statement dated 11/5/09, complete Initial CN dated 12/8/09, nocturnal test results 12/8/09, multiple delivery tickets.
Missing: Physician clinical documentation within 30 days prior to initial CMN and a valid delivery ticket for concentrator.

Example 3: E1390

Documentation Received: supplier cover sheet, nocturnal testing results 5/18/09-5/19/09, complete Initial CMN dated 5/19/09, complete Recertification CMN dated 5/19/10, Revised CMN dated 10/1/10 adding portable oxygen, hospital admission note dated 1/22/09.
Missing: physician clinical documentation within 30 days prior to the initial CMN, physician clinical documentation within 90 days of recertification CMN, ongoing physician clinical notes to indicate patient still requires home oxygen therapy.

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

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

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

Suppliers are encouraged to review the following references:

- The *Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)* **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

- The *DME MAC Jurisdiction A Supplier Manual* **http://www.medicarenhic.com/dme/suppmandownload.shtml**
  - "Welcome Page" provides valuable information to the CMS Web sites
  - Chapter 10: includes information regarding documentation requirements

- *January -May 2011 CERT Error articles*
  http://www.medicarenhic.com/dme/articles/021811_CERT-Errors.pdf

- *CERT Physician Letter - Oxygen & Supplies*
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_oxy.pdf

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

- *Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439)* (Posted March 25, 2011 and June 9, 2010)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

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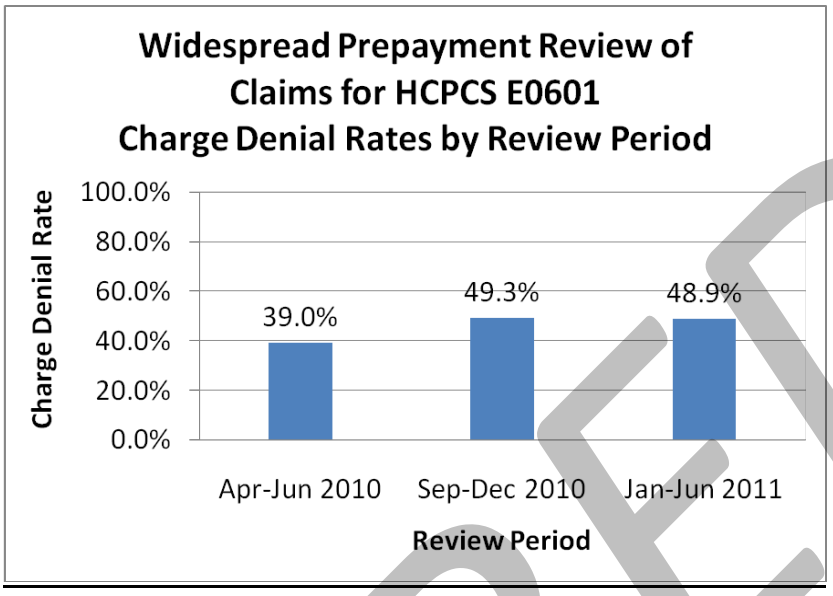
Results of Widespread Prepayment Review of Claims for HCPCS E0601, (Continuous Positive Airway Pressure Devices) (SPE)

Historical Review Results
DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices, HCPCS E0601, based on the results of previous quarterly findings. The previous quarterly findings covered the period from September 2010 through December 2010 and resulted in a 49.3% 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 (HCPCS E0601). These findings include claims with dates of service primarily from January 2011 through June 2011. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 828 claims submitted by 369 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 123 (15%) of the claims. Of the 705 claims for which responses were received, 337 claims were allowed and 368 were denied. This resulted in a claim denial rate of 52%. 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 48.9%.

Charge Denial Rate Historical Data
The following graph depicts the Charge Denial rate from previous periods to current:



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

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

Face to Face Clinical Evaluation documentation issues

- 37% of the denied claims were missing required clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. Examples of no clinical documentation received include:
  - No face to Face clinical evaluation from the beneficiary's medical record or documented in the history section of the polysomnogram (Sleep Study) provided in the claim.
  - No Face to Face clinical re-evaluation documented in the beneficiary's medical record within 31 and 91 days of initiation of therapy to allow for continuing coverage of the PAP device beyond the first 3 months. This document is meant to describe improvement in subjective symptoms of OSA and objective data related to compliance with PAP therapy.
  - No Face to Face evaluation conducted by the treating physician found in the claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare.
- 3% of the denied claims had insufficient clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. Examples of no clinical documentation received include:
  - Clinical documentation provided in the claim did not reflect the need for the care provided. No detailed narrative in the clinical documentation describing presenting symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores (the sleep hygiene inventory).
  - Face to Face clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued benefit from sleep therapy.
  - Insufficient clinical documentation found in Face to Face evaluations conducted by the treating physician in the claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare.
- 4.3% of the denied claims were missing the signature and/or date on the Face to Face clinical evaluation.
- 1% of the denied claims had illegible Face to Face documents.

Detailed written order issues

- 2% of the denied claims did not include the MD detailed order.
- 2.2% of the denied claims had detailed written orders that were not signed by the treating physician or were signed and dated by the treating physician after the date of service. There was no start date on the written order and dispensing order (verbal) order was not included with claim to verify start date.
- 0.27% of the denied claims had detailed written orders that were illegible.
- 0.54% of the denied claims had detailed written orders that were not dated by the treating physician.

Sleep Study documentation issues

- 2.2% of the denied claims did not include a copy of the original Medicare covered sleep study.
- 2% of the denied claims had sleep study documents that were not signed by an entity that qualifies as a Medicare provider of sleep tests.
- 1.6% of the denied claims had sleep study documents that did not meet coverage criteria per the PAP LCD.
- 0.27% of the denied claims had illegible sleep study documents.

Proof of Delivery documentation issues

- 15% of the denied claims did not include proof of delivery
- 0.27% of the denied claims had proof of delivery that did not include a beneficiary or designee signature when delivered directly to the beneficiary
- 1% of the denied claims did not include a date on the proof of delivery.
- 0.54% of the denied claims had proof of delivery that was illegible.

Training documentation issues

- 21% of the denied claims did not include evidence of training on the PAP device.

Miscellaneous

- 5% of the claims were denied as duplicate submissions

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 may occur with CPAP claims:

Example 1:

Received: Claim consisted of 7 pages, with a note from the supplier on page 3 that read "additional documentation to follow", "Patient has been on CPAP since 2005". The remaining pages consisted of two dated progress notes.

Missing: According to supplier this claim was for a replacement PAP device. The Face to Face clinical evaluation (10/26/10) submitted with claim did not give an explanation for the need to replace the PAP device. In addition, documentation in the note did not include evidence that the beneficiary continued to use and benefit from the PAP device. Most of the note was illegible. Medicare requires that services provided be authenticated by the treating practitioner. There was no real or electronic signature found on the Face to Face clinical evaluation conducted by the treating physician on 10/26/10. The second progress note submitted in this claim was dated after the date of service, therefore not applicable as a valid Face to Face. The MD detailed order, proof of delivery, and evidence of training on the new device were not included with the claim.

Example 2:

Received: Included in the claim was a letter from the supplier indicating the information provided for review was incomplete. Per the supplier, the Face to Face clinical evaluation "was not available to include with this mailing. Upon receipt of this information, it will be provided." Documentation provided in the claim included: the MD detailed order, the Sleep Study titration, a "brief summary of pertinent findings" of the original Sleep Study, the proof of delivery/Patient Agreement and Consent form, and a 24 page description of the PAP device to demonstrate training.

Missing: Documentation provided with the claim did not include an initial Face to Face clinical evaluation prior to the Sleep Study conducted on 11/8/10. Documents provided did not include the interpretation/findings of the original Medicare covered sleep test. The claim included only the titration study and a brief description of the original findings - "CPAP titration was successful". Insufficient information was given to determine if coverage criteria was met. When comparing the items billed on the claim with the items listed on the proof of delivery, it was found the quantities of A7039 (non-disposable filters) supplies were greater than those described in the policy as the usual maximum amounts. Medicare was billed for 2 filters for this date of service whereas the allowable was 1 A7039 per 6 months.

Example 3:

Received: Documentation provided with this claim include signed/dated Sleep Study and titration study, a MD detailed order, and evidence that the beneficiary has been trained on the use and proper care of the PAP device.

Missing: Documentation provided did not include a Face to Face clinical evaluation prior to the Sleep Study that addressed evidence of current symptoms of a sleep disorder including but not limited to snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches or a valid Epworth Sleepiness Scale. There was no proof of delivery provided. Reviewer was unable to determine if beneficiary received the items ordered by the prescribing physician. In addition, the scoring technician made note in the titration study that the beneficiary "did not like the CPAP air or mask but did tolerate it. She said she would NOT use a CPAP at home."

Next Step

Based on the results of this prepayment review, DME MAC A will continue to review claims billed for Continuous 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
- *Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601)*: posted 3/4/2011 and 7/2/2010
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/030411_E0601.pdf
- *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
- *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
- *March 2011 CERT Errors*
  http://www.medicarenhic.com/dme/articles/050611_CERT-Errors.pdf
- *Frequently Asked Questions* (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faq_results.asp?categories=DME

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

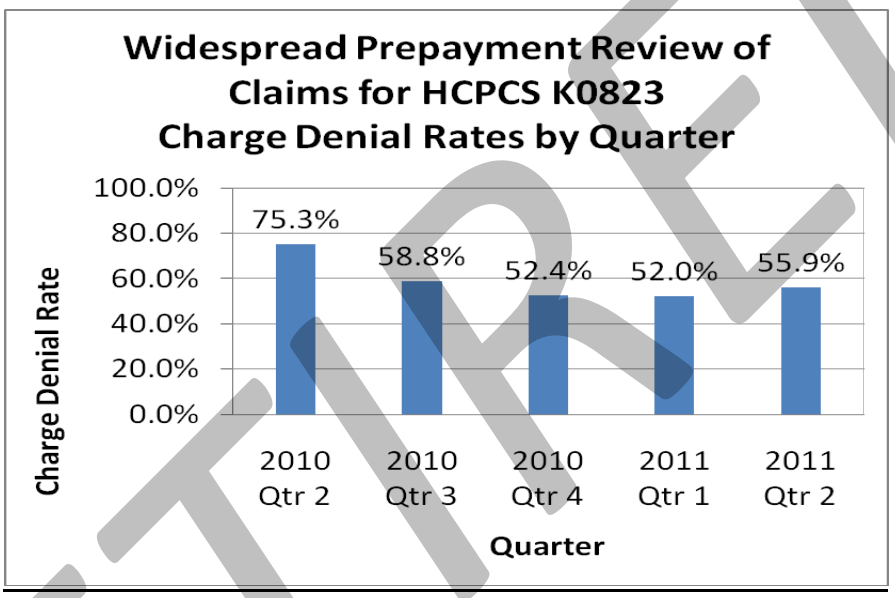
Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from January 01, 2011 through March 31, 2011 and resulted in a 52.0% percent Charge Denial Rate (CDR).

Current Review Results
DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS K0823). These findings include claims with dates of service from April 01, 2011 through June 30, 2011. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 868 claims submitted by 241 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 15% of the claims. Of the 738 claims for which responses were received, 320 claims were allowed and 418 were denied. This resulted in a claim denial rate of 57%. 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 55.9%.

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



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

Insufficient Documentation

- 57% of the denied claims had insufficient clinical documentation to support medical necessity. The medical record information submitted was insufficient to show that the coverage criteria listed in the Local Coverage Determination (LCD) were met. Examples of insufficient clinical documentation received include:
  - Clinical records did not include medical documentation from the ordering clinician's Face to Face Power Mobility Exam, (F2F exam) to substantiate that a patient is prevented from accomplishing Mobility Related Activities of Daily Living, (MRADL's) due to mobility deficits.
  - Clinical records failed to detail specific reasons why the patient is at risk for morbidity or mortality while attempting to perform MRADL's, i.e., injury from falls and physical stressors to the body.
  - F2F power mobility evaluations did not include a comprehensive physical exam that provided objective measurements to provide a clear picture of the patient's specific mobility limitations, i.e., upper and lower body strength, range of motion, coordination, pain levels, physical deformities and physical endurance.
  - Clinical documentation frequently failed to address the possible use or trials of other alternative mobility assistive devices.

7-element Order Issues

- 8.1% of the denied claims did not include all the required 7-elements
- 10.5% of the denied claims had 7-element orders that did not include confirmation the supplier received a copy within 45 days after the completion of F2F, (as verified by a supplier date stamp or equivalent)
- 3% of the denied claims did not contain a 7-element order
- 0.14% of the denied claims had illegible 7-element orders

Lack of Home Assessment

- 6% of the denied claims did not include evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair, (PWC).

Detailed Product Description Issues

- 2.6% of the denied claims provided no detailed product description.
- 1.7% of the denied claims did not include a list of supplier's charges and a Medicare fee schedule allowance on the detailed product description.
- 6.5% of the denied claims did not note that the supplier received, signed and dated the detailed product description prior to the delivery of the device.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with K0823 claims:

Example 1:

Received: Clinical documentation submitted was limited and described the visit as a follow up visit for left knee pain. The documentation noted that the patient complained of left knee pain, right hand and wrist numbness and difficulty ambulating around the house because of back and leg pain. It was noted that the examination showed left knee tenderness, lumbar tenderness and bilateral hand tenderness. Patient had full range of motion in all joints. Patient told the doctor a power wheelchair would help her complete her ADL'S. It was recommended by her doctor that she limit activities that increase her discomfort and take pain relief medications as prescribed.

Missing: Documentation failed to note that the purpose of the medical exam was for a face to face power mobility exam. Clinical documentation did not provide objective measurements of the patient's lower and upper extremity weakness and extent of pain. Documentation failed to give a history on the use of other alternative mobility assistive devices. It was not documented as how the patient's clinical issues impacted the ability to attend to and complete MRADL'S safely and effectively. Documentation should objectively address mobility limitations and provide a clear picture of the patient's mobility deficits. Objective measurements should be provided.

Example 2:

Received: A 7-element order dated 1/3/11 from the ordering clinician, but the claim submitted was for a date of service and the delivery of the device on 12/29/10. Delivery was prior to the 7-element order being written.

Missing: Documentation did not include a 7-element order written on or before the date of service of 12/29/11. For a power wheelchair to be covered, the supplier must receive from the treating physician a written 7-element order within 45 days after the completion of the physician's face-to-face exam and *prior to the delivery of the device*.

Example 3:

Documentation failed to provide proof that a home assessment took place on or before delivery of the power wheelchair.

Missing: Documentation did not include confirmation of a home assessment being conducted to verify the patient can adequately maneuver the power wheelchair in the home considering physical layout, doorway width, thresholds and surfaces.

Next Step

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

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

Educational References
NHIC Corp. DME MAC and CMS provide extensive educational offerings related to the proper documentation requirements for K0823 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

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

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

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

- *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

- *Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds)* (published March 11, 2011)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/030411_k0823.pdf

- *Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds)* (published November 05, 2010)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/110510_K0823.pdf

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

- *Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements*
  http://www.cms.gov/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf

- *Power Mobility Device Face-to-Face Examination Checklist* (SE1112)
  http://www.cms.gov/mlnmattersarticles/downloads/SE1112.pdf

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

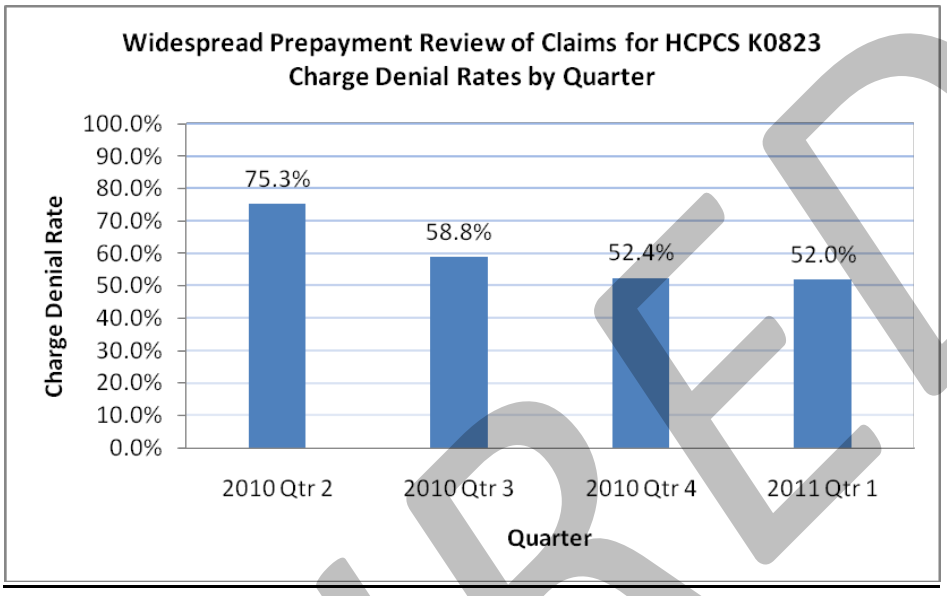
Historical Review Results
DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from October 01, 2010 through December 31, 2010 and resulted in a 52.4 percent Charge Denial Rate (CDR).

Current Review Results
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS K0823). These findings include claims with dates of service primarily from January 2011 through March 2011. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 768 claims submitted by 225 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 135 (17%) of the claims. Of the 633 claims for which responses were received, 297 claims were allowed and 336 were denied. This resulted in a claim denial rate of 53%. The total denied allowance amount (dollar

amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 52.0%.

Charge Denial Rate Historical Data
The following graph depicts the Charge Denial rate from previous quarters to current, reflecting a slight improvement over the past quarters:



Primary Reasons for Denial
Based on the review the following are the primary reasons for denial:

Insufficient clinical documentation to support medical necessity

- 47% of the denied claims had insufficient clinical documentation to support medical necessity. The medical record information submitted was insufficient to show that the coverage criteria listed in the local coverage determination (LCD) were met. Examples of insufficient clinical documentation received include:
  - Clinical records did not include medical documentation from the ordering clinician's Face to Face Power Mobility Exam, (F2F exam) to substantiate that a patient is prevented from accomplishing Mobility Related Activities of Daily Living, (MRADL's) due to mobility deficits.
  - Clinical records failed to detail specific reasons why the patient is at risk for morbidity or mortality while attempting to perform MRADL's, i.e., injury from fall risk, over exertion, pulmonary or cardiac stress issues.
  - F2F power mobility evaluations did not include a comprehensive physical exam that detailed the patient's specific mobility limitations, i.e., upper and lower body strength, range of motion, coordination, pain levels, physical deformities and physical endurance.
  - Clinical documentation often was insufficient as it did not address historical perspectives of the patient's mobility issues and the prior use of other mobility assistive devices.

7 Element order issues

- 11% of the denied claims did not include all the required 7 elements
- 11% of the denied claims had 7 element orders that did not include confirmation the supplier received a copy within 45 days after the completion of F2F, (as verified by a supplier date stamp or equivalent)
- 5.7% of the denied claims were missing the 7 element order
- 1% of the denied claims had illegible 7 element orders

Lack of Home Assessment

- 14% of the denied claims did not include evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair, (PWC).

Proof of Delivery issues

- 8% of the denied claims were missing proof of delivery.
- 1.8% of the denied claim delivery tickets did not include all the items listed on the detailed product description,
- 6% of the denied claim delivery tickets were not signed by the beneficiary.

Claim Examples

As an additional educational measure, the following are actual examples of claim denials. NHIC expects that these examples will assist suppliers in understanding the medical review process and the documentation errors that occur with K0823 claims:

Example 1:

Received: Clinical documentation submitted was limited, describing the patient as status post coronary artery bypass graft, with hypertension and status post hip surgery resulting in weakened lower extremities and some upper extremity weakness. The documentation noted that the patient uses a cane and walker, along with using furniture for support, but requires a motorized wheelchair.

Missing: Clinical documentation did not provide objective measurements of the patient's lower and upper extremity weakness. Documentation failed to give results of the use of the cane and walker as mobility assistive devices. Documentation did not include information as to whether a manual wheelchair had been considered for mobility assistance. The documentation was not specific on how the cardiac or hip surgeries have impacted the patient's mobility issues. It was not documented as how the patient's clinical issues impacted the patient's ability to attend to and complete MRADL'S safely and effectively.

Example 2:

Received: A brief progress note and a physician addendum/attestation. Progress note only noted the vital signs, the diagnosis and a plan to get a wheelchair. Addendum/ attestation reports that the patient suffers from renal failure, arthropathy and diabetes mellitus, which affects ability to ambulate and puts patient in danger of falling.

Missing: Documentation did not include a detailed evaluation of the patient's mobility-related abilities and limitations or a historical perspective of the patient's mobility status. The face to face mobility exam was lacking vital information in the form of a comprehensive exam which, at minimum should address upper and lower body strength, ROM, endurance and the ability to attend to and complete MRADL's. Documentation was insufficient as it did not objectively address mobility limitations and provide a clear picture of the patient's mobility deficits. Sufficient objective measurements were not provided.

Example 3:

Received: A supplier generated form filled out by the ordering clinician labeled "mobility evaluation for motorized wheelchair consult".

The consult cited that the following:

Patient has arthritis in both legs and takes Tylenol for the pain.

Patient has problems standing and walking for long periods.

Patient is obese and does not have enough upper body strength to move a wheelchair on her own. A power wheelchair will allow patient to easily move from place to place in her home.

Patient can walk 20 feet without stopping and can stand without assistance.

Missing: Documentation does not include a comprehensive mobility exam conducted by the ordering clinician, that addresses the patient's specific mobility related abilities and limitations, as well as, a historical perspective of the patient's mobility status. There was no documentation that indicated if the patient could benefit from any other type of mobility device. There were no objective clinical measurements documented to explain how severe the patient's mobility deficit is.

Next Step

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

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

NHIC appreciates the hard work by suppliers that has resulted in the improvements in the error rate over the past year. We encourage all suppliers to continue to examine their K0823 claims for compliance with all of the LCD requirements.

Educational References
NHIC provides extensive educational offerings related to the proper documentation requirements for K0823 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

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

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

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

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

- *Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds)* (published 3/11/2011)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/030411_k0823.pdf

- *Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds)* (published 11/5/2010).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/110510_K0823.pdf

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

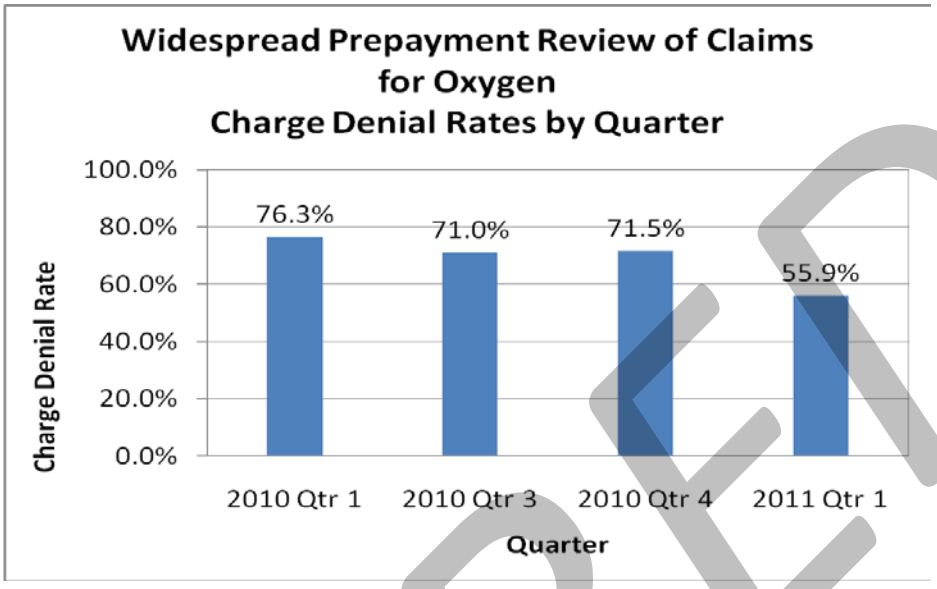
Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment, HCPCS E1390, E0431, and E0439 (OXY)

Historical Review Results
DME MAC A Medical Review continues to review Oxygen and Oxygen Equipment, based on the results of previous quarterly findings. The previous quarterly findings covered the period of October 2010 through December 2010 and resulted in a 71.5 % Charge Denial Rate (CDR).

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

The review involved prepayment complex medical review of 297 claims submitted by 199 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 124 (42%) of the claims. For the remaining 173 claims, 70 claims were allowed and 103 were denied resulting in a claim denial rate of 60%. 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 55.9%.

Charge Denial Rate Historical Data
The following table depicts the Charge Denial Rate from previous quarters to current.



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

Treating physician visits- Missing documentation

- 42.7% of the denied claims were missing the treating physician visits (both 30 days prior to initial CMN and 90 days prior to recertification CMN) documentation
- 24.3% of the denied claims were missing the treating physician visit (30 days prior to initial CMN) documentation
- 1.9% of the denied claims were missing the treating physician visit (90 days prior to recertification CMN) documentation

Documentation received: Medical necessity could not be established

- 7% of the denied clams had inconsistent documentation such as out of date order documents and incomplete documents. Examples include:
  - Initial CMN dated 6/14/10; delivery ticket dated 9/3/08; could not validate oxygen saturation.
  - Received multiple CMNs - last initial is dated 2/13/09 - prior is dated 1/14/05 no changes in rate, supplier, physician - new delivery 2/13/09 however, it is before 5 year Reasonable Useful Lifetime (RUL). Cannot allow, as during 37-60 timeframe. No ABN submitted.
  - Inconsistent information submitted. Lacking physician clinical notes 30 days prior to initial date of 7/30/08 - a re-cert CMN was submitted with a change in initial date. Oxygen saturation testing included with a 1/7/08 physician visit - however, no delivery for oxygen until 7/30/08
  - Inconsistent documentation to allow for medical necessity. Dispensing order is written in 2009 along with the delivery date in 2009 - the initial CMN received was an initial in 2010 and the testing was dated in 2010. The “initial” visit was dated in Sept 2010 and listed as a re-cert evaluation appointment for oxygen.
- 1% of the claims were denied due to indication of PRN use
- 1% of the claims were denied because the oxygen saturation level could not be validated with any documentation submitted.
- 1% of the claims were denied because the nocturnal testing did not meet medical necessity criteria.

Certificate of Medical Necessity (CMN) Issues

- 3.9% of the denied claims were missing the initial CMN.
- 1% of the denied claims had CMNs that were not signed or dated by the physician.

Delivery Ticket Issue

- 1% of the claims were denied because the delivery ticket did not correspond to the start Initial CMN date.

Other Documentation issues

- 3.8% of the denied claims had illegible documentation
- 2% of the denied claims had returned ADRs with no accompanying documentation

Billing and Miscellaneous Issues

- 3% of the denied claims involved billing issues
  - Billed in error (equipment picked up)
  - Billed in error (voluntary refund)
  - Patient deceased
- 2% of the denied claims were for duplicate submissions.

Claim Examples

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

Example 1:

Documentation received: Physician's complete order, completed Initial CMN (7/2/09) indicating patient oxygen sat met the Group I criteria , completed Revised CMN (7/2/10), valid delivery ticket (7/2/09), beneficiary authorization (7/2/09), supplier initial set-up checklist, verbal order, supplier plan of care.

Missing:

Testing requirement: Blood gas study from the most recent study obtained within 30 days prior to the Initial CMN date.

Visit requirement: The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification, and the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of Recertification.

Example 2:

Documentation received: Referral Form from discharging hospital (6/2/08), oxygen desaturation study (5/31/08), complete physician order (5/31/08 and 2/24/11), complete Initial CMN (6/2/08) with oxygen saturation listed meeting Group I criteria, complete Recertification CMN (6/2/09), treating physician visit dated 1/31/2011, valid delivery ticket (6/2/08), beneficiary authorization (6/2/08), supplier care plan, supplier assessment form.

Missing:

Visit requirement: The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification, and the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of Recertification.

Example 3:

Documentation received: Complete Physician order (12/21/08), complete Initial CMN(12/22/08) with oxygen saturation listed meeting Group I criteria , complete Recertification CMN(12/22/09), physician visit dated 10/14/10, valid delivery ticket (12/22/08), beneficiary authorization (12/22/08).

Missing:

Testing requirement: Blood gas study from the most recent study obtained within 30 days prior to the Initial CMN date.

Visit requirement: The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification, and the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of Recertification.

Example 4:

Received: Verbal order 2/15/10, beneficiary authorization 2/16/10, valid delivery ticket 2/16/10, initial CMN 2/23/10 with oxygen desaturation testing meeting Group I criteria, illegible physician order, nocturnal testing 2/23/10-2/24/10 total time 88% or less = 36 seconds.

Missing:

Valid testing requirement: nocturnal testing did not record 5 minutes meeting criteria at or below 88 percent taken during sleep. The 5 minutes does not have to be continuous.

Visit requirement: The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification, and the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of Recertification.

Next Step

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

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

NHIC appreciates the hard work by suppliers that has resulted in the improvements in the error rate over the past year. We encourage all suppliers to continue to examine their E1390, E0431 and E0439 claims for compliance with all of the LCD requirements.

Educational References

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

- *Oxygen and Oxygen Equipment (L11468) LCD*
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

- *Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment, HCPCS E1390, E0431 and E0439* , posted , June 9, 2010, November 5, 2010, and March 25, 2011.
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.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

- *January 2011 CERT Errors*
  http://www.medicarenhic.com/dme/articles/021811_CERT-Errors.pdf

- *CERT Physician Letter - Oxygen & Supplies*
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_oxy.pdf

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

Supplies Used With Functional Electrical Stimulators (FES) - E0770 (SPE)

Electrodes used with a covered E0770 (FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED) are eligible for reimbursement as long as the E0770 device meets the coverage criteria outlined in the CMS National Coverage Determination and are used by the patient. Functional electrical stimulators are a type of neuromuscular stimulator (NMES); therefore, supply codes used with NMES devices are to be used with FES devices. Electrodes are billed with code:

A4595 - ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)

A4595 is an allowance for all necessary supplies used during the month regardless of the number of lead/electrode changes made. All necessary supplies such as electrodes, coupling gel, adhesive, adhesive remover, etc. are considered as included in the monthly allowance. If two FES leads/electrodes are required then a maximum of one unit of Code A4595 would be allowed per month; if four FES leads/electrodes are necessary, a maximum of two units per month would be allowed.

There is no separate payment for supplies provided with an initial claim. Initial provision of an E0770 includes all necessary supplies. Separate billing of supplies with the initial claim is considered unbundling.

For additional information about the coverage of FES and supplies, refer to CMS IOM Pub. 100-03 *National Coverage Determination (NCD) Manual*, section 160.12.

Widespread Prepayment Review for Home Blood Glucose Monitor Supplies - HCPCS Codes A4253 (BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS) and A4259 (LANCETS, PER BOX OF 100) (SPE)

DME MAC A will be initiating a widespread prepayment review of claims for home blood glucose monitor supplies, HCPCS codes A4253 (BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS) and A4259 (LANCETS, PER BOX OF 100).

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

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

Documentation should include the following per the Local Coverage Determination (LCD) for Glucose Monitors (L11530):

- Physician's detailed written orders
- New physician's detailed written order when change in testing frequency
- Physician progress notes/medical records
- Documentation of beneficiary's training and capability in the use of glucose supplies
- Proof of request for a refill
- Proof of Delivery with name, address, signature of beneficiary or designee, and glucose supplies provided
- Invoice
- Any other pertinent documentation that would support the medical necessity of the item(s) billed
- If there is an Advanced Beneficiary Notice of Noncoverage (ABN) on file, this must be submitted with all of the above requested documentation

If refills of quantities of supplies that exceed the utilization guidelines are dispensed, the following additional documentation must be submitted:

- Documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed
- If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months

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

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and Policy article. Suppliers can review the *LCD for Glucose Monitors (L11530)* on the NHIC Web site at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

All aboard the "DMEPOS Express"... next stop... knowledge!
http://www.medicarenhic.com/dme/dme-eduonline.shtml#podcast

Ask-the-Contractor Teleconference (ACT) Q&A - June 22, 2011 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Wednesday, June 22, 2011 as a teleconference/webinar on the topic of Updates and Hot Topics. A presentation was provided followed by an open Q&A 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: Do you know when DMEPOS suppliers will be allowed to submit their re-enrollment requests through PECOS?

A1: DMEPOS suppliers can currently use Internet-based PECOS to enroll, make a change in their enrollment record, view their Medicare enrollment information on file with Medicare, and check on the status of a Medicare enrollment application via the Internet.

For additional PECOS information, refer to the following resources:

- DME MAC A Web site: **http://www.medicarenhic.com/dme/dme_pecos.shtml**
- CMS Website: **http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp**

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

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

For additional information, refer to the NSC Web site at: **http://www.palmettogba.com/nsc**

Q3: What is the correct address to send correspondence to the Jurisdiction A Medical Director?

A3: Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr
Hingham, MA 02043

Q4: How do we bill if a pt is on oxygen 5 liters per minute (LPM) with a portable system?

A4: Per the LCD for Oxygen and Oxygen Equipment, if basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the patient is on 4 LPM meets Group I or II criteria. If a patient qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen, payment will be made for the stationary system at the higher allowance, but not for the portable system. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied as not separately payable. The QF modifier must be used if the prescribed flow rate is greater than 4 LPM and portable is also prescribed. This modifier may only be used with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). The QF modifier must not be used with codes for portable systems or oxygen contents.

Q5: We have received a few oxygen medical record requests as part of the widespread prepayment probe currently being conducted by Jurisdiction A. How far back do we have to provide medical documentation?

A5: There is no specified time period for which suppliers are required to collect records. Typically, the record retention rule requires records to be available for 7 years unless state law is more stringent. For most items, the relevant records are dated close to the initial date of service. Records that document continued need must be timely to the date of service being reviewed.

Q6: What documentation is needed if we are using upgrade modifiers with items in the LCD for Oxygen and Oxygen Equipment?

A6: Per the Revised - *Use of Upgrade Modifiers* article, a supplier may charge their "usual and customary" fee for the upgraded item that is provided.

Q7: Can a Certificate of Medical Necessity (CMN) serve as the detailed written order?

A7: The CMN can serve as the physician's detailed written order if the narrative description in section C is sufficiently detailed. This would include quantities needed and frequency of replacement for accessories and supplies. For items requiring both a CMN and a written order prior to delivery (seat lift mechanisms and TENS units) suppliers may utilize a completed and physician-signed CMN for this purpose. Otherwise, a separate order in addition to a subsequently completed and signed CMN is necessary.

Q8: What is the proper modifier to use when billing for labor to a base piece of equipment that was initially denied as not reasonable and necessary and an Advance Beneficiary Notice (ABN) was properly obtained?

A8: Medicare does not cover labor to equipment that is not reasonable and necessary. Therefore, if you have an ABN on file for both the base piece of equipment and the labor charge, the GA modifier would be appropriate.

Q9: If a patient is requesting CPAP supplies but the order is expired can we create a form/script and fax it to the MD for him to sign? Is there a requirement that the physician has to see a patient in any timeframe for him to sign a script?

A9: After verbally communicating with the physician, the supplier can create a detailed written order based on the verbal discussion that includes an itemized listing of all directly related, separately billable items. This detailed written order is then returned to the physician for their signature. The supplier must have the detailed written order back in their possession prior to submitting a claim.

Q10: If we accept an order written by a physician who is not in PECOS, can we be held accountable in the event that there is an audit related to PECOS implementation?

A10: CMS has not yet identified exactly what activities will occur with regard to audits specific to PECOS enrollment.

Q11: Can a participating supplier collect any money up front from the Medicare patient or are we required to wait for the EOB?

A11: "Participation" means you agree to always accept assignment on claims for all covered services you furnish to Medicare patients. By agreeing to accept assignment, you agree to always accept Medicare allowed amounts as payment in full and you may not collect any more than the Medicare unmet deductible and coinsurance from the beneficiary for covered services.

Q12: What is the policy for Group II oxygen if the patient re-tests at 90 days and are still 89%?

A12: If the patient retest between the 61st and 90th day after the initial date and the results still fall within the Group II qualifications, the patient would be certified for lifetime.

Q13: For PAP, does the download for compliance need to be exactly 30 days or could it be more?

A13: The download for compliance could be more; however, the compliance data must be a consecutive 30 days.

Q14: Can we have access to same or similar information for diabetic footwear?

A14: Unfortunately, same similar information is not currently available for HCPCS codes beginning with the letters A, L, or V. In order to receive this information, suppliers must speak directly with a customer service representative.

Q15: Who is authorized to provide a verbal order?

A15: A supplier must have an order from the "treating physician" before dispensing any DMEPOS item to a beneficiary. A nurse practitioner, clinical nurse specialist, or physician assistant may also give the dispensing order and sign the detailed written order but only if they meet the applicable requirements outlined in Chapter 5 of the CMS *Program Integrity Manual* at **http://www.cms.gov/manuals/downloads/pim83c05.pdf**

Q16: When is PECOS going to be enforced?

A16: At this time CMS has not turned on the automated edits that would deny claims for services that were ordered or referred by a physician or other eligible professional simply for lack of an approved file in PECOS. CMS has not yet determined when it will begin to apply the expanded edit for ordering/referring provider claims but when they do, CMS will provide ample advance notice to the provider and beneficiary communities before beginning such automatic denials.

Billing Reminder - Arformoterol (Brovana) Number of Units (DRU)

Arformoterol inhalation solution (J7605) is a long-acting bronchodilator with beta-adrenergic stimulatory effect and is used for the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0-508.9).

Suppliers must be sure that they use the correct billing units when calculating the number of units of service to enter on the claim.

Aformoterol is allowed twice per day for a total of 30mcg per day (2 units per day). Units should not exceed 2 per day, per patient. Each unit is 15 mcg.

When billing Arformoterol (J7605), two vials/units x number of days in the month = the maximum number of units.

The maximum number of units per month for Arformoterol (J7605) is 62 (930 mcg.).

Drug Name	HCPCS	Unit of Service(UOS)	Maximum/month	Maximum UOS/month
Arformoterol	J7605	15 mcg	930 mcg/month	62

Billing Reminder - Lower Limb Suction Valve Prosthesis (O&P)

Use of HCPCS Code L5647, L5652 and L5671 - Reminder

L5671 describes both the part of the suspension locking mechanism that is integrated into the prosthesis socket and the pin(s), lanyard, or other component which is attached to the socket insert. L5671 does not include the socket insert itself.

Code L5647 describes a type of suspension system and is intended for use with sockets that incorporate a suction valve in their design.

The parallel code for above knee prostheses is code L5652 (addition to lower extremity, suction suspension, above knee or knee disarticulation socket).

Codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design. The items described by these codes are not components of a suspension locking mechanism (L5671); therefore Medicare does not allow separate billing or payment for code L5671.

Billing Reminder - Maximum Allowable of PAP and RAD Accessories (SPE)

Accessories used with a PAP and/or RAD device are covered when the coverage criteria for the device are met. If the coverage criteria are not met, the accessories will be denied as not reasonable and necessary.

The following table represents the usual maximum amount of accessories expected to be reasonable and necessary:

PAP and RAD Accessories

HCPCS Code	Usual Maximum Amounts
A4604	1 per 3 months
A7027	1 per 3 months
A7028	2 per 1 month
A7029	2 per 1 month
A7030	1 per 3 months
A7031	1 per 1 month
A7032	2 per 1 month
A7033	2 per 1 month
A7034	1 per 3 months
A7035	1 per 6 months
A7036	1 per 6 months
A7037	1 per 3 months
A7038	2 per 1 month
A7039	1 per 6 months
A7046	1 per 6 months

Quantities of supplies greater than those described in the policy as the usual maximum amounts will be denied as not reasonable and necessary.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization.

Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients.

Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three (3)-month quantity of PAP and RAD accessories at a time.

* If you are billing more than the usual maximum allowable, be sure to include information as to why the additional units are necessary. This information should be entered in the NTE 2300 or 2400 field of electronic claims or Item 19 of paper claims.

Billing Reminder - Repairs to Capped Rental Durable Medical Equipment (DME) (GEN)

Payment for capped rental DME is made on a rental basis for a period not to exceed 13 months of continuous use. Payment for all maintenance, servicing, and repair of capped rental DME is included in the allowed rental payment amounts. Therefore, under no circumstances should separate payment be made for these services prior to the end of the 13-month capped rental period.

This basic rule has been in place since the date that the DME fee schedules and capped rental payment rules went into effect on January 01, 1989.

If you submit a claim for DME repairs that were done to a piece of equipment during the capped rental period your claim will be either rejected or denied. The following ANSI Reason Code, Remark Codes and Medicare Summary Notice (MSN) messages will be generated:

> **97:** The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. NOTE: Refer to the 835 healthcare policy identification segment (loop 2110 service payment information ref), if present.
>
> **MA 13:** Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
>
> **N211:** Alert: You may not appeal this decision.
>
> **MSN 16.35:** You do not have to pay for this amount.
>
> **MSN 16.35:** Usted no tiene que pagar esta cantidad.

Additional information is available in the CMS *Medicare Benefit Policy Manual*, Chapter 15, section 110.2 (A) at **http://www.cms.gov/manuals/Downloads/bp102c15.pdf**

Billing Reminder - Urological Supplies (SPE)

The DME MAC A Outreach & Education Team would like to remind the supplier community that many urological supply HCPCS codes include payment for other items. In these cases, the included items are not separately payable by Medicare and should not be submitted on the claim.

When providing the urological supply HCPCS listed in Column II, the Column I code must be used instead of billing separate Column II codes when the items are provided at the same time.

Column I	Column II
A4310	A4332
A4311	A4310, A4332, A4338
A4312	A4310, A4332, A4344
A4313	A4310, A4332, A4346
A4314	A4310, A4311, A4331, A4332, A4338, A4354, A4357
A4315	A4310, A4312, A4331, A4332, A4344, A4354, A4357
A4316	A4310, A4313, A4331, A4332, A4346, A4354, A4357
A4354	A4310, A4331, A4332, A4357
A4357	A4331
A4358	A4331, A5113, A5114
A5105	A4331, A4358, A5112, A5113, A5114
A5112	A5113, A5114

If a urological supply HCPCS code exists that includes multiple products, that code should be used in lieu of the individual codes.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items. The PDAC can be reached at 1-877-735-1326 or **http://www.dmepdac.com**

Common Electronic Data Interchange (CEDI) Listserv (GEN)

To stay informed of all CEDI updates, visit the CEDI Web site at **http://www.ngscedi.com** and sign up for the CEDI Listserv by selecting the Listserv Registration Link. You will then be prompted to submit your email address and name to subscribe. This listserv is for all entities participating with CEDI whether you are a software vendor, a third-party billing agency or a supplier performing your own EDI transmissions.

Hospital Beds with Mattresses, Group I and Group II Support Mattresses (MOB)

When the beneficiary owns or is renting a medically necessary **group I** (E0184, E0186, E0187, E0196) or **group II** support mattress (E0277, E0373) and a hospital bed becomes medically necessary, Medicare will deny the hospital bed if the item provided to the beneficiary includes a mattress (Healthcare Common Procedure Coding System (HCPCS) Codes E0250, E0255, E0260, E0265, E0290, E0292, E0294, E0296, E0303, E0304, E0328, and E0290).

Jurisdiction A DME MAC will begin issuing an American National Standards Institute (ANSI) 150 same/similar denial on claims for hospital beds **with mattresses** when the patient is currently renting or owns a medically necessary group I or II support mattress.

If there is a change in the beneficiary's condition which results in the need for a different item (i.e., a hospital bed and a group II support surface), Medicare would consider payment. However, at no time will Medicare allow for a hospital bed **with mattress** and a support surface classified as a mattress (i.e., group I support mattress [E0184, E0186] or group II support mattress [E0277, E0373]) at the same time.

Helpful Tips
Suppliers should verify if the beneficiary is renting or owns a medically necessary group I or II support mattress, or a hospital bed with mattress, by checking Option 7 Same or Similar on the *Interactive Voice Response (IVR)* (**http://www.medicarenhic.com/dme/contacts/DME_MAC_A_IVR_User_Guide.pdf**).

If the supplier determines the beneficiary is renting or owns a medically necessary group I or II support surface mattress, they should deliver the appropriate hospital bed **without mattress** (HCPCS Codes E0251, E0291, E0256, E0293, 0261, E0295, E0266, E0297, E0301, or E0302) and bill the appropriate corresponding HCPCS code to the DME MAC.

Medicare considers a group I or II support surface same or similar to a hospital bed mattress. If the beneficiary is renting or owns a medically necessary hospital bed with mattress and their condition changes and they require and receive a group I or group II support mattress (E0184, E0186, E0277, E0373) they must notify the supplier so that billing can be modified for the hospital bed. At that time, suppliers may pick up the hospital bed mattress that the patient is no longer using or can opt to leave the hospital bed mattress in the patient's home.

If the hospital bed mattress is picked up, suppliers should bill using a hospital bed HCPCS code where the narrative indicates that a **mattress is not included** (E0251, E0256, E0261, E0266, E0291, E0293, E0295, E0297, E0301, and E0302).

If the beneficiary requests to keep the hospital bed mattress, suppliers may execute an Advance Beneficiary Notice of Noncoverage (ABN). In that situation the supplier should bill using the upgrade modifiers.

Line 1: Bill the appropriate HCPCS code for the upgraded item the supplier actually provided to the beneficiary (hospital bed with mattress) with the dollar amount of the upgraded item. If the supplier has a properly obtained ABN on file signed by the beneficiary, report modifier GA; if the supplier did not properly obtain an ABN signed by the beneficiary, report modifier GZ.

Line2: Bill the appropriate HCPCS code for the reasonable and necessary item (hospital bed without mattress) with the actual charge for the item; report modifier GK.

The following examples explain how to file claims with an ABN and without an ABN.

Example 1

Upgraded with an ABN	**E0260RRKHGA**	**$100**
Medically necessary item	E0261RRKXKHGK	$50

Example 2

Upgrade without an ABN	**E0260RRKHGZ**	**$100**
Medically necessary item	E0261RRKXKHGK	$50

The NHIC, Corp. DME MAC Local Coverage Determinations (LCDs), are located at:
http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

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Revised Advanced Beneficiary Notice of Noncoverage (ABN) - Required for Use on November 01, 2011 (GEN)

The Revised Advanced Beneficiary Notice of Noncoverage (ABN), FORM CMS-R-131, is now available and required for use on November 01, 2011.

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

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

Notifiers are required to use the revised ABN beginning **November 01, 2011**.

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

Join the NHIC, Corp. DME MAC A ListServe!

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

Second Quarter 2011 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for April through June 2011, are provided in the following table.

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 - Invalid Procedure Code and/or Modifier	163,372	The procedure code, modifier, or procedure code and modifier combination is invalid.
C044 - Subscriber Primary ID Invalid	41,290	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	31,281	The item (whether for purchase or rental) is classified as a capped rental item (or possibly a pen pump item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.
B108 - Billing provider not authorized for submitter	21,511	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	21,033	The Tax ID (Employer Identification Number/Social Security Number) that was submitted does not match what is on file with the NPPES or the National Supplier Clearinghouse (NSC).
C095 - Diagnosis Code Invalid - Pointer 1	20,899	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
C003 - Billing NPI Not Found on Crosswalk	18,344	There is no link between the NPI that was submitted and a PTAN/NSC.
C180 - Service Date Greater than Receipt Date	18,007	The service start/from date is greater than the date this claim was received.
A051 - Subscriber postal ZIP code is invalid	17,292	The subscriber's ZIP code is missing or invalid. The ZIP code must be a valid US Postal Service Code. The ZIP code must be numeric. The ZIP code must not be all zeroes and/or all nines.
C179 - Service From/To Dates Not Equal	16,304	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.

Second Quarter 2011 - Top Return/Reject Denials

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

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

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	31,432
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.	11,071
CO 16 N64 - Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,086
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).	2,308
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.	1,961
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.	1,887
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).	728
CO 16 M51, N225, N29 - Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	636
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.	631
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.	588

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.

New Electronic Mailing List Promoting Events & Training Opportunities (GEN)

DME MAC A has developed a new electronic mailing list specific to **Supplier Training & Event News** in an effort to promote awareness of the various educational and training offerings that are available to the DME MAC A supplier community in support of increasing your Medicare knowledge and reducing claim errors related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

As a subscriber to this ListServe, you will be kept informed of the availability of a wide range of training opportunities delivered by a variety of methods:

- In person events/seminars/tradeshows
- Webinars
- Ask-the-Contractor Teleconferences (ACTs)
- Self-paced tutorials
- Podcasts
- Supplier quizzes
- Much more

If you are interested in adding the new **Supplier Training & Event News** list to a new profile, or adding the new list to your existing subscription, visit **http://www.medicarenhic.com/dme/listserve.html** and enter your email address. Individuals that are already subscribed to any of our other lists will receive an email with further instructions. New subscribers must complete all remaining fields and select the lists in which they are interested. Upon saving your new profile, a welcome email will be generated to indicate successful subscription.

DME MAC A ListServes (GEN)

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

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

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

Quarterly Provider Update (GEN)

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

Supplier Manual News (GEN)

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

Updates/Corrections Made:
In June of 2011 chapters 1, 2, 4, 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.

MLN Special Edition Article #SE1126

"*Further Details on the Revalidation of Provider Enrollment Information*"
http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf

Do **NOT** submit your revalidation until you are notified to do so by your MAC. You will receive a notice to revalidate between now and March 2013.

For Your Notes

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

Helpful Contacts

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

September 2011
Number 21

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
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