DME MAC Jurisdiction A Resource
INFORMATION FOR DME MAC SUPPLIERS in CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, & VT

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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 web site at:
www.medicarenhic.com/dme

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2012-2013 Seasonal Influenza (Flu) Resources for Health Care Professionals (SE1242) (GEN)

MLN Matters® Number: SE1242
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation Date: NA

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide seasonal flu vaccines and vaccine administration provided to Medicare beneficiaries.

What You Need to Know

- Keep this MLN Matters® Special Edition Article and refer to it throughout the 2012 - 2013 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don't forget to immunize yourself and your staff.

Introduction

Annual outbreaks of seasonal flu typically occur as early as October and as late as May, with peak months in January and February. Illness from seasonal flu usually lasts one to two weeks, and flu-related complications include pneumonia and dehydration. Approximately 5 to 20 percent of Americans catch the seasonal flu each year. Getting the flu vaccine is your best protection against the flu (*Flu.gov. 2012. Seasonal Flu [online]. Washington D.C.: The U.S. Department of Health and Human Services, 2010 [cited 3 October 2012]. Available from the World Wide Web:* **http://www.flu.gov/about_the_flu/seasonal/index.html**)

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)

Protect You and Your Family From the Flu!

You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don't forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don't forget to immunize yourself and your staff.

Educational Products for Health Care Professionals

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

1. MLN Seasonal Influenza Related Products for Health Care Professionals

- ***MLN Matters Article MM8047: Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season*** - This article contains the payment allowances for the 2012-2013 flu season. You can download it at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8047.pdf** on the CMS website.

- ***Quick Reference Information: Medicare Part B Immunization Billing*** - This educational tool is designed to provide education on Medicare-covered preventive immunizations. Available in print and as a downloadable PDF at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf** on the CMS website.

- ***Quick Reference Information: Preventive Services*** - This educational tool is designed to provide education on the Medicare-covered preventive services. Available as a downloadable PDF at **http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf** on the CMS website.

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

- ***Preventive Services Educational Products PDF*** - This PDF provides a list of all MLN products related to Medicare-covered preventive services. View this PDF at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf** on the CMS website.

2. Other CMS Resources

- **Seasonal Influenza Vaccines 2012 Pricing** is at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2012ASPFiles.html** on the CMS website.

- **Prevention General Information Overview** is at **http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html** on the CMS website.

- **CMS Frequently Asked Questions** are available at **http://questions.cms.gov/faq.php** on the CMS website.

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

- ***Medicare Claims Processing Manual*** **- Chapter 18, Preventive and Screening Services** available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf** on the Internet.

3. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase seasonal flu vaccine awareness and utilization during the 2012 - 2013 flu season:

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

Beneficiary Information

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

Vaccination is the Best Protection Against the Flu - Influenza Vaccine Prices Are Now Available. Each office visit is an opportunity to check your patients' seasonal influenza (flu) and pneumonia immunization status and to start protecting your patients as soon as your 2012-2013 seasonal flu vaccine arrives. Ninety percent of flu-related deaths and more than half of flu-related hospitalizations occur in people age 65 and older. Seniors also have an increased risk of getting pneumonia, a complication of the flu. Remind your patients that seasonal flu vaccinations and a pneumococcal vaccination are recommended for optimal protection. Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries. Medicare may provide coverage of additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible. And don't forget to immunize yourself and your staff. Know what to do about the flu.

Remember - Influenza vaccine plus its administration and pneumococcal vaccine plus its administration are covered Part B benefits. Influenza vaccine and pneumococcal vaccine are NOT Part D-covered drugs. CMS has posted the 2012-2013 *Seasonal Influenza Vaccines Pricing* (**http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html**). You may also refer to the *MLN Matters® Article #MM8047* (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8047.pdf**), "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season."

For more information on coverage and billing of the flu vaccine and its administration, please visit the *CMS Medicare Learning Network® Preventive Services Educational Products* (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html**) and *CMS Immunizations* (**http://www.cms.gov/immunizations**) web pages. And, while some providers may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. *HealthMap Vaccine Finder* (**http://flushot.healthmap.org/**) is a free, online service where users can search for locations offering flu vaccines

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2013 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update (MM8037) (GEN)

MLN Matters® Number: MM8037
Related CR Release Date: September 7, 2012
Related CR Transmittal #: R2542CP

Related Change Request (CR) #: CR 8037
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for 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.

Provider Action Needed

Impact to You

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in CR8037 could impact your payments.

What You Need to Know

This article is based on Change Request (CR) 8037 which provides the 2013 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 2012:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled 2013 Carrier/A/B MAC Update) will be posted at **http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html** 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 2013 FI/A/B MAC Update) will be posted to **http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html** on the CMS website.

What You Need to Do

It is **important and necessary** for you to read 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 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 110.4.1 (Annual Update Process) for carriers and A/B MACs, and Section 20.6 (SNF CB Annual Update Process for Fiscal Intermediaries) for FI and A/B MACs. You can find this manual at **http://www.cms.gov/Regulations-and-Guidance/Guidance/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

The official instruction, CR8037 issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2542CP.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Alert Concerning Impacts Arising from Having Non-Compliant Physical or Practice Address Information on File with Medicare (SE1245) (GEN)

MLN Matters® Number: SE1245
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: Not applicable (N/A)
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and A/B MACs) for services to Medicare beneficiaries.

Provider Action Needed

Impact to You

The purpose of this Article is to alert physicians, providers, and suppliers that you need to ensure that your designated FI, carrier, DME MAC or A/B MAC no longer has a Post Office (P.O.) Box or Lock Box address in association with your Billing Provider Address information on file for you.

Impacts to Institutional Providers

- For 837 institutional claims, the volume of claims that receive error H25375 - "The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-to Provider Address" - and therefore are not crossed over for processing by another payer is approximately 7,500 claims per week.
- The problem of institutional claims rejecting with error H25375 is particularly acute for providers in Puerto Rico, some of whom unfortunately may be experiencing a 100 percent rejection rate for their institutional crossover claims.

Impacts to Physicians and Suppliers

- Nationally, by comparison, the incidence of H25375 rejections for 837 professional claims for all states and United States territories is roughly 1,000 per week.

What You Need to Know

The Accredited Standards Committee (ASC) X12 Standard for Electronic Data Interchange (EDI) Technical Report Type 3 (TR-3) Guides prohibit inclusion of a P.O. Box or Lock Box Address within the Billing Provider Address (2010AA N301 and N302) segments of any health care claims exchanged electronically between or among *Health Insurance Portability and Accountability Act* (HIPAA) "covered entities," which include providers, health plans, and clearinghouses.

Creation of Bill-to Provider Address Information on Outbound Medicare Coordination of Benefits (COB) Claims

Medicare uses information stored within its internal provider or supplier files for claims payment as well as for Coordination of Benefits (COB)/Medicare claims crossover purposes. Specifically, the Medicare claims processing systems use on-file physical or practice address information from these data sources in the creation of the required Bill-to Provider (2010AA) name and address elements.

HIPAA Compliance Errors Impacting Medicare Crossover Claims

The Centers for Medicare & Medicaid Services (CMS) highlighted the ongoing problem of Medicare crossover claims failing HIPAA compliance at its Coordination of Benefits Contractor (COBC) due to the presence of a P.O. Box or Lock Box within the 2010AA N301 and N302 segments at recent Provider Enrollment, Chain, and Ownership System (PECOS) conferences. This MLN Matters® Special Edition Article also alerts you to this important concern so that you can act to remedy the problem if it affects you.

What You Need to Do

If you or your billing offices are receiving provider notification letters from Medicare that reflect error H25375 as the basis for why your patients' claims cannot be crossed over - or that otherwise are encountering a 100 percent incidence of their patients' Medicare claims not being crossed over - you should contact your local jurisdictional FI, carrier, DME MAC, or A/B MAC to confirm what street address information Medicare has on file for you.

Your Medicare contractor will be able to advise you about what actions involving completion of an on-line 855 application may be necessary to ensure that PECOS and the associated internal Medicare provider and supplier files will reflect your street address for your physical address or practice address, as applicable. Make sure that your billing staffs comply with this Special Notice, if necessary.

Additional Information

If you have any questions, please contact your FI, carrier, DME MAC, or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment (SE1238) (GEN)

MLN Matters® Number: SE1238
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition (SE) Article is intended for providers and suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article highlights the April 2012 report from the Office of the Inspector General (OIG) titled "Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment." The article also focuses on the Medicare policy regarding the required documentation suppliers must have on file.

The objective of this OIG study was to determine whether the KX modifier was effective in ensuring that DMEPOS suppliers who submitted Medicare claims had the required supporting documentation on file. The study included individual reviews of the four contractors that processed the DMEPOS claims for Jurisdictions A through D with dates of service in 2007.

The OIG report focused on the following four categories of DMEPOS claims containing the KX modifier for Calendar Year (CY) 2007:

1. therapeutic shoes for diabetics,
2. continuous positive airway pressure systems,
3. respiratory assist devices, and
4. pressure reducing support surfaces (groups 1 and 2).

Background

Medicare providers and suppliers have a vital role in helping the Centers for Medicare & Medicaid Services (CMS) effectively manage Medicare resources. CMS acknowledges the daily challenges providers and suppliers face in serving Medicare beneficiaries and the complex process involved in obtaining and receiving the required documentation.

For certain DMEPOS, suppliers must use the KX modifier. The KX modifier indicates that the claim meets Medicare coverage criteria and the supplier has the required documentation on file. While suppliers must have a written physician's order and proof of delivery for all DMEPOS, suppliers must have additional documentation on file for items requiring the KX modifier. For example, therapeutic shoes also require that a certifying physician's statement be on file before the supplier bills Medicare.

OIG Findings

The report found that in CY 2007:

1. 60% of the sampled 400 claims, suppliers did not have the required documentation on file;
2. 37% of the claims were missing the physician orders;
3. 21% were missing proof of delivery;
4. 25% were missing use or complaint use follow-up statements; and
5. 2% were missing sleep studies.

The Key Points section below reviews Medicare policy for coverage of therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2). Each DMEPOS has similar requirements that will be listed first. For additional document requirements, each DMEPOS will be listed thereafter.

Key Points

CMS reminds physicians that in order for these items to be reimbursed for their patients, the DME supplier must collect medical documentation. This includes copies of the initial evaluation and any other reports needed to comply with coverage criteria specific to:

1. therapeutic shoes for diabetics;
2. continuous positive airway pressure systems;

3. respiratory assist devices; and
4. pressure reducing support surfaces (groups 1 and 2).

Cooperation and coordination between physicians and suppliers is necessary to meet Medicare coverage documentation requirements and deliver effective and efficient healthcare to beneficiaries.

The Local Coverage Determinations (LCDs) for all four DME MACs require suppliers to have the same documentation on file for the categories of DMEPOS and dates of service included in this OIG audit. Additional coverage and payment rules for therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (groups 1 and 2) may be found in the LCDs for the applicable DME MAC. **See the Additional Information section below to find websites for all four contractors.**

The complete medical policy is posted on individual DME MAC websites, or in the CMS Medicare Coverage Database. The database is available at **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx** on the CMS website. Each category of DMEPOS in this study requires the following documentation:

1) Valid written order that contains:
   - Beneficiary's name;
   - Treating physician's signature;
   - Date the treating physician signed the order, and
   - Start date of the order.
2) Proof of delivery.

Additional documentation requirements for each category of DMEPOS are also listed as follows:

Therapeutic Shoes

1) Signed statement from the certifying physician (must be MD or DO) who is treating the patient's systemic diabetes condition;
   - Patient has diabetes mellitus; and
   - Patient has one of the following:
     a. Previous amputation of the other foot, or part of either foot; or
     b. History of previous foot ulceration of either foot; or
     c. History of pre-ulcerative calluses of either foot; or
     d. Peripheral neuropathy with evidence of callus formation of either foot; or
     e. Foot deformity of either foot; or
     f. Poor circulation in either foot.

Certify that the above two indications are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes; and the patient needs diabetic shoes.

2) Documentation of an in-person evaluation of the patient by the certifying physician who is managing the patient's systemic diabetes condition within 6 months specifying:
   a. The patient has diabetes mellitus;
   b. Has one of the conditions 2a-2f listed in Policy Article A37076 (**http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=37218&ver=14&ContrId=137**);
   c. Is being treated under a comprehensive plan of care for his/her diabetes, and
   d. Requires diabetic shoes.

3) Documentation of an in-person evaluation of the patient by the supplier prior to selection of the items billed that included:
   a. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
   b. For all shoes, taking measurements of the patient's feet.
   c. For custom molded shoes and inserts, taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.

4) Medical records supporting that the patient has diabetes mellitus and at least one of the conditions noted above.

5) Documentation of an in-person visit with the patient by the supplier at the time of delivery must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

Note: *Please refer to the basic coverage criteria specified in the Therapeutic Shoes LCD for your DME MAC for further guidance.*

Continuous Positive Airway Pressure Systems

1) Documentation of a verbal order (if item is dispensed based on a verbal order) that contains:
   a. Description of the item;
   b. Name of the beneficiary;
   c. Name of the physician, and
   d. Start date of the order.

2) Valid written order that contains:
   a. Beneficiary's name
   b. Treating physician's signature
   c. Date the treating physician signed the order
   d. Start date of the order-if the start date differs from the signature date.
   e. Order for PAP with pressure setting.

3) Beneficiary Authorization.

4) Proof of Delivery.

5) Face-to-Face clinical evaluation by the physician prior to the sleep test to assess the patient for obstructive sleep apnea (OSA) containing the following elements:
   a. Sleep history and symptoms which may be caused by OSA;
   b. Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory, and
   c. Pertinent physical examination - e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam.

6) Medicare-covered sleep test that meets either of the following criteria:
   a. Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) greater than or equal to15 events per hour with a minimum of 30 events; **OR**
   b. AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
      i. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, **OR**
      ii. Hypertension, ischemic heart disease, or history of stroke.

7) Documentation that the patient and/or caregiver received instruction from the supplier of the Positive Airway Pressure (PAP) device and accessories in the proper use and care of the equipment.

8) To continue coverage for the PAP device (Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD)) beyond an initial 3-month trial period, there must be:
   a. A face-to-face visit with the physician during the second or third month of the trial that documents an improvement of the beneficiary's symptoms; and
   b. A data report from the PAP device which documents use of the PAP device for at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.

9) For beneficiaries who received a PAP device prior to Fee-For-Service (FFS) Medicare enrollment and are now enrolled in Medicare and are seeking a new PAP device and/or accessories, both of the following coverage requirements must be met:
   a. Sleep test - There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories, and,
   b. Clinical Evaluation - Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:
      i. The beneficiary has a diagnosis of obstructive sleep apnea; and,

ii. The beneficiary continues to use the PAP device.

Note: *Please refer to the basic coverage criteria specified in the PAP LCD by your DME MAC contractor for further guidance.*

Respiratory Assist Devices

1) Documentation of a verbal order (if item is dispensed based on a verbal order) that contains:
   a. Description of the item;
   b. Name of the beneficiary;
   c. Name of the physician, and
   d. Start date of the order.

2) Valid written order that contains:
   a. Beneficiary's name
   b. Item to be dispensed
   c. Pressure setting with or without backup rate
   d. Treating physician's signature
   e. Date the treating physician signed the order
   f. Start date of the order if the start date differs from the signature date.

3) Beneficiary Authorization.

4) Proof of Delivery.

5) Medical records documenting:
   a. Symptoms characteristic of sleep-associated hypoventilation.
   b. Patient has one of the following disorders and meets all coverage criteria for that disorder:
      i. Restrictive Thoracic Disorder, or
      ii. Severe COPD, or
      iii. Central Sleep or Complex Sleep Apnea, or
      iv. Hypoventilation Syndrome.

Note: *Please refer to the basic coverage criteria specified in the RAD LCD by your DME MAC contractor for further guidance.*

Pressure Reducing Support Surfaces (groups 1 and 2)

1) Valid written order that contains:
   a. Beneficiary's name
   b. Treating physician's signature
   c. Date the treating physician signed the order
   d. Start date of the order if the start date differs from the signature date.
   e. Clear, detailed description of the type of support surface the physician is ordering.

2) Beneficiary Authorization.

3) Signed statement from the treating physician indicating what, if any, payment criteria the patient meets.

4) Medical records supporting patient meets the basic coverage criteria specified in the Pressure Reducing Support Surfaces- Group 1 and 2 LCD.

Note: *Please refer to the basic coverage criteria specified in the Pressure Reducing Support Surfaces- Group 1 and 2 LCDs by your DME MAC contractor for further guidance.*

Additional Information

For questions about documentation requirements, please contact your DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

The OIG report titled "*Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment*" is available at **http://oig.hhs.gov/oas/reports/region4/41004004.pdf** on the OIG website.

The Medicare Learning Network® (MLN) fact sheet titled "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf** on the CMS website.

The DME MAC websites are available as follows:

- Cigna Government Services **http://www.cgsmedicare.com/jc/index.html**
- National Government Services **http://www.ngsmedicare.com/**
- National Heritage Insurance Company (NHIC) **http://www.medicarenhic.com/dme/index.asp**
- Noridian Administrative Services **https://www.noridianmedicare.com/dme/index.html**

Claim Status Category and Claim Status Codes Update (MM8045) (GEN)

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Provider Types Affected

This MLN Matters® Article is intended for 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 (DME) MACs) for Medicare beneficiaries are affected.

Provider Action Needed

This article, based on Change request (CR) 8045, explains that Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277, Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the national Code Maintenance Committee meetings.

These codes explain the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/** or **http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/** on the Internet. Make sure that your billing staffs are aware of these updates.

Background

The *Health Insurance Portability and Accountability Act* (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use. All code changes approved during the June 2012 committee meeting will be posted on the Internet on or about July 1, 2012.

Additional Information

The official instruction, CR8045, issued to your Medicare contractor regarding this change, may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2547CP.pdf** on the CMS website. If you have any questions, please contact your FI, carrier, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Clarification of the Quality Standards and Accreditation Requirements for Ultra Lightweight Manual Wheelchairs (SE1233) (MOB)

MLN Matters® Number: SE1233
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: March 1, 2013
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Medicare contractors (DME Medicare Administrative Contractors (DME MACs)) for certain wheelchairs and related services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

Effective for claims with dates of service on or after March 1, 2013, suppliers who furnish K0005 wheelchairs to Medicare beneficiaries and who are not in compliance with DMEPOS Quality Standards and Accreditation Requirements must come into compliance with these requirements or they will be required to stop furnishing these items to Medicare beneficiaries until these requirements are met.

What You Need to Know

Ultra lightweight manual wheelchairs (Healthcare Common Procedure Coding System (HCPCS) code K0005) are highly configurable manual wheelchairs for highly active full time users.

The ultra-light weight manual wheelchairs require individualized fitting and optimal adjustments for multiple features that include axle configuration, wheel camber, and seat and back angles, in addition to ongoing critical support.

These services are furnished by a Rehabilitative Technology Supplier (RTS). Therefore, these items are considered complex rehabilitative wheelchairs subject to the requirements of DMEPOS Quality Standards, Appendix B, Manual Wheelchairs, Power Mobility Devices (PMDs), and Complex Rehabilitative Wheelchairs and Assistive Technology, **Section III, Complex Rehabilitative Wheelchairs and Assistive Technology.** You must employ at least one Assistive Technology Professional effective for services on or after March 1, 2013 in order to bill Medicare for the K0005 wheelchair. See Background section of this article for further information about Appendix B.

All other lightweight manual wheelchairs are considered standard lightweight wheelchairs and are subject to the requirements of DMEPOS Quality Standards, Appendix B, Section I, Manual Wheelchairs.

What You Need to Do Go Light

Make sure that your staffs are aware of these requirements.

Background

The complete set of requirements, including Appendix B, may be found in the booklet entitled "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards*," available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf** on the CMS website. Here is the text of appendix B of the DMEPOS Quality Standards.

Appendix B: Manual Wheelchairs, Power Mobility Devices, and Complex Rehabilitative Wheelchairs and Assistive Technology

This appendix applies to Manual Wheelchairs, Power Mobility Devices (PMDs), and Complex Rehabilitative Wheelchairs and Assistive Technology. Manual wheelchairs include standard recliners, heavy-duty wheelchairs, standard lightweight wheelchairs, and hemi wheelchairs, armrests, leg rests/footplates, anti-tipping devices, and other Medicare approved accessories. PMDs include power wheelchairs and Power Operated Vehicles (POVs) and accessories. Complex Rehabilitative wheelchairs are Group 2 power wheelchairs with power options, Group 3 power wheelchairs and manual wheelchairs that can accommodate rehabilitative accessories and features (e.g., tilt in place).

I. Manual Wheelchairs

A. Intake & Assessment

In addition to Section II: Supplier Product-Specific Service Requirements (in the booklet entitled "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards*"), the supplier shall verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary's record.

B. Delivery & Set-up

Refer to Section II: Supplier Product-Specific Service Requirements.

C. Training/Instruction to Beneficiary and/or Caregiver(s)

Refer to Section II: Supplier Product-Specific Service Requirements.

D. Follow-up

Refer to Section II: Supplier Product-Specific Service Requirements.

II. Power Mobility Devices

A. Intake & Assessment

In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary's record.

B. Delivery & Set-up

Refer to Section II: Supplier Product-Specific Service Requirements.

C. Training/Instruction to Beneficiary and/or Caregiver(s)

Refer to Section II: Supplier Product-Specific Service Requirements.

D. Follow-up

Refer to Section II: Supplier Product-Specific Service Requirements.

III. Complex Rehabilitative Wheelchairs and Assistive Technology

In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall:

1. Employ (W-2 employee) at least one qualified individual as a Rehabilitative Technology Supplier (RTS) per location. A qualified RTS is an individual that has one of the following credentials:
    - Certified Rehabilitative Technology Supplier (CRTS);
    - Assistive Technology Supplier (ATS) (discontinued 12/31/2008);
    - Assistive Technology Practitioner (ATP) (discontinued 12/31/2008);
    - Assistive Technology Professional (ATP) (effective 1/1/2009).

2. The RTS shall have at least one or more trained technicians available to service each location appropriately depending on the size and scope of its business. A trained technician is identified by the following:
    - Factory trained by manufacturers of the products supplied by the company;
    - Experienced in the field of Rehabilitative Technology, (e.g., on the job training, familiarity with rehabilitative clients, products and services);
    - Completed at least 10 hours annually of continuing education specific to Rehabilitative Technology; and
    - Able to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.

3. The RTS shall:
    - Coordinate services with the prescribing physician to conduct face-to-face evaluations of the beneficiary in an appropriate setting and include input from other members of the health care team (i.e., PT, OT, etc.);
    - Provide the beneficiary with appropriate equipment for trial and simulation, when necessary;
    - Maintain in the beneficiary's record all of the information obtained during the assessment; and
    - Implement procedures for assembly and set-up of equipment as well as a process to verify that the final product meets the specifications of the original product recommendation approved by the prescribing physician.

4. If beneficiaries are evaluated in the supplier's facility, the supplier shall:
    - Provide the beneficiary private, clean, and safe rooms appropriate for fittings and evaluations; and
    - Maintain a repair shop located in the facility or in close proximity or easily accessible from another location of the supplier, as well as an area appropriate for assembly and modification of products.

A. Intake & Assessment
In addition to Section II: Supplier Product-Specific Service Requirements, the supplier shall verify that seating, positioning and specialty assistive technology have been evaluated and documented in the beneficiary's record.

B. Delivery & Set-up
Refer to Section II: Supplier Product-Specific Service Requirements.

C. Training/Instruction to Beneficiary and/or Caregiver(s)
Refer to Section II: Supplier Product-Specific Service Requirements.

D. Follow-up
Refer to Section II: Supplier Product-Specific Service

Additional Information

If you have any questions, please contact your DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Durable Medical Equipment (DME) National Competitive Bidding (NCB): National Mail Order (NMO) Program Implementation for Diabetic Supplies (MM8080) (SPE)

MLN Matters® Number: MM8080 Revised
Related CR Release Date: November 1, 2012
Related CR Transmittal #: R1139OTN
Related Change Request (CR) #: 8080
Effective Date: July 1, 2013
Implementation Date: July 1, 2013

Note: *This article was revised on November 6, 2012 to remove the words "and accept" from the second paragraph on page 2. All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) suppliers that submit claims for Medicare payment to Durable Medical Equipment (DME) Medicare Administrative Contractors (DME MACs) for diabetic supplies delivered to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8080 and reminds suppliers that, effective July 1, 2013, Medicare Part B payment for covered diabetic testing supplies delivered to a Medicare beneficiary' s home by any method is subject to the NMO Competitive Bidding Program. This program applies throughout the United States with the exception of the Northern Mariana Islands.

Once the program goes into effect, beneficiaries with Original Medicare who get diabetic testing supplies delivered to their homes will have to use a Medicare contract supplier in order for Medicare to make payment unless an exception applies. Suppliers that are awarded an NMO contract will be required to furnish mail order diabetic testing supplies to beneficiaries with Original Medicare in 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. Beneficiaries residing in the Northern Mariana Islands are not included in the NMO program.

Key Points

- Beneficiaries may choose to pick up diabetic testing supplies in person from retail pharmacy locations or other local supplier storefronts or have them delivered to their homes. Once the program is implemented, only NMO contract suppliers will be reimbursed by Medicare Part B for providing diabetic testing supplies delivered to beneficiaries' residences. If the supplies are shipped or delivered by any means to the beneficiary's home, then the supplier that furnished the supplies must be a NMO contract supplier for Medicare to pay.
- The only diabetic testing supplies not included in the program are those that are obtained directly by a beneficiary or caregiver by physically going to an enrolled DMEPOS supplier storefront and leaving the store with the diabetic testing supplies.
- The only supplier that can bill for these non mail-order diabetic supplies is the supplier from which the beneficiary or caregiver physically picked up the supplies. Diabetic supplies furnished by any means other than mail-order or pickup are not payable by Medicare.
- The term "mail-order" means items shipped or delivered to the beneficiary's residence by any method.
- All suppliers are required to use the KL modifier on each claim for diabetic supplies furnished on a mail-order basis. Suppliers that furnish diabetic testing supplies on a mail-order basis that do not attach the mail-order modifier could be subject to significant penalties.
- Claim lines for items subject to the NMO program for diabetic supplies provided by a non-contract supplier on or after July 1, 2013 will be denied, For paid claim lines where the submitted charge exceeds the single payment amount in the contract, the remittance will be the single payment amount. Contract suppliers must accept assignment for items in their contracts.

Background

CR 8080 provides guidance for systems changes in preparation for NMO program implementation. Section 302 of the *Medicare Modernization Act* of 2003 (MMA) established requirements for a new competitive bidding program (CBP) for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

The *Medicare Improvements for Patients and Providers Act* (MIPPA) authorized competition for national mail order items and services after 2010.

Additional Information

The official instruction, CR 8080 issued to your DME MAC regarding this change, may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1139OTN.pdf** on the CMS website. If you have any questions, please contact your carrier or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website. Providers may find more detailed information about the competitive bidding program at **http://www.cms.hhs.gov/DMEPOSCompetitiveBid/** on the CMS website.

Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856) (SE1011) (GEN)

MLN Matters® Number: SE1011 Revised **Related Change Request (CR) #: 6421, 6417, 6696, 6856**
Related CR Release Date: N/A **Effective Date: N/A**
Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R7810TN **Implementation Date: N/A**

Note: *This MLN Matters® Article was revised on October 23, 2012, to add a reference to SE1221 available at* **http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE1221.pdf** *for information on Phase II of the implementation of Ordering/Referring requirements for Part B DME and Part A HHA claims that will result in denial of those claims for items or services that were furnished based on the good order or referral from a provider who does not have a Medicare enrollment record. This article was previously revised on September 17, 2012, to change the reference to Certified Clinical Nurse Specialist on page 3 to say Clinical Nurse Specialist. Also, we have added a reference to MLN Matters® Article SE1221 in the Additional Information section of the article. All other information remains the same.*

Provider Types Affected

This Special Edition MLN Matters® Article is intended for physicians, non-physician practitioners (including interns, 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), Part A Regional Home Health Intermediaries, Fiscal Intermediaries who still have a Home Health Agency (HHA) workload 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 a Medicare enrollment record, 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-855O). Review the background and additional information below and make sure that your billing staffs are aware of these updates.

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: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA 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 record and must be of a specialty that is eligible to order and refer.

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.

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, DME and Part A HHA 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; and
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS.

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,
- Clinical Nurse Specialist,
- Nurse Practitioner,
- Clinical Psychologist,
- Interns, Residents, and Fellows,
- 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 Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and it contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider 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:** 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 is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message (The informational messages vary depending on the claims processing system.) in the Medicare Remittance Advice (DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.) indicating that the claim failed the ordering/referring provider edits.

  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. The informational messages are identified below:

  For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering physician provider name
N265	Missing/incomplete/invalid ordering physician primary identifier

  For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.
  DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

  For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

  For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

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 CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits.** In Phase 2, if the Ordering/Referring Provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral. The denial edits are identified below:

  Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

  CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 - This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237 - This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

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. (NPIs were added only when the matching criteria verified the NPI.)

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 bi-weekly 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/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html**; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

Effect of Edits on Providers

1. ***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.**
   - If you are not sure you are enrolled in Medicare, 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 and it contains your NPI; (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or (3) use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare). 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 Medicare:**
     - 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 either e-sign the certification statement or mail a printed, signed, and dated 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/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html**, 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.
       b. **Submit an electronic application through the use of internet-based PECOS or obtain a paper enrollment application**, 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 order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, 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-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (**http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html**).

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).

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 (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

2. 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 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 Medicare enrollment records 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 bi-weekly to ensure it is current. 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 appeal 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. 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 denied because they failed the Ordering/Referring Provider would expose the Medicare beneficiary to liability. Therefore, **an Advance Beneficiary Notice is not appropriate.**

Additional Guidance

1. **A note on terminology:** Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

2. **Orders or referrals by interns or residents.** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.

3. **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-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

4. **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-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review MLN Matters® Article SE1201 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf**) and SE1221 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1221.pdf**) for important reminders on the requirements for Ordering and Referring Physicians. If you have questions, please contact your Medicare Carrier, Part A/B MAC, or DME MAC, at their toll-free numbers, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Effect of Beneficiary Agreements Not to Use Medicare Coverage and When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician/Practitioner (MM8100) (GEN)

MLN Matters® Number: MM8100
Related CR Release Date: October 26, 2012
Related CR Transmittal #: R160BP

Related Change Request (CR) #: CR 8100
Effective Date: January 28, 2013
Implementation Date: January 28, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8100 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending Chapter 15, Section 40.6 of the "*Medicare Benefit Policy Manual*" to be consistent with current regulations. In addition, CMS is making some other minor changes to sections 40 through 40.40 of the same manual in order to update those sections of the manual.

Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Section 4507 of the *Balanced Budget Act* of 1997 amended section 1802 of the *Social Security Act* ("the Act") to permit certain physicians and practitioners to opt-out of Medicare if certain conditions were met, and to provide through private contracts services that would otherwise be covered by Medicare.

The purpose of CR8100 is to modify section 40.6 of the "*Medicare Benefit Policy Manual*," Chapter 15, because to be consistent with the policy described in Medicare regulations at 42 CFR 405.435(c). That regulation permits Medicare payment to be made for claims submitted by a beneficiary for the services of an opt out physician or practitioner when the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the Medicare contractor that the physician or practitioner has opted out of Medicare.

Additional Information

The official instruction, CR 8100, issued to your carrier or A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R160BP.pdf** on the CMS website. The revised manual sections are attached to CR8100. If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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

MLN Matters® Number: SE1126 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was updated on July 25, 2012, to reflect current Web addresses. Previously, the article was revised on December 9, 2011, to provide the calendar year 2012 fee amount of $523.00. 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf** on the CMS website. **This article provides no new policy, but only provides further information regarding the revalidation requirements based on Section 6401 (a) of the *Affordable Care Act.***

What You Need to Know

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

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

What You Need to Do

When you receive notification from your MAC to revalidate:

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

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

Background

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

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

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

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

- **For providers NOT in PECOS** - the revalidation letter will be sent to the special payments or primary practice address because CMS does not have a correspondence address.

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

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

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

To revalidate via the Internet-based PECOS, go to **https://pecos.cms.hhs.gov/pecos/login.do** 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. For CY 2012, the fee is $523.00. CMS has defined "institutional provider" to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application.

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

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

Additional Information

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

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

The MLN fact sheet titled "*The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations*" is designed to provide education to provider and supplier organizations on how to use Internet-based

PECOS to enroll in the Medicare Program and can be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf** on the CMS website.

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

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

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

Hurricane Sandy and Medicare Disaster Related Claims (SE1247) (GEN)

MLN Matters® Number: SE1247
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in the States of New York and New Jersey who were affected by Hurricane Sandy.

What You Need to Know

On October 30, 2012, pursuant to the Robert T. Stafford *Disaster Relief and Emergency Assistance Act*, President Obama declared that, as a result of the effects of Hurricane Sandy, a major disaster exists in the State of New Jersey, retroactive to October 26, 2012. On November 1, 2012, Secretary Sebelius of the Department of Health & Human Services (HHS) declared that a public health emergency exists in the State of New Jersey and authorized waivers and modifications under Section 1135 of the *Social Security Act*, retroactive to October 26, 2012.

Also on October 30, 2012, pursuant to the Robert T. Stafford *Disaster Relief and Emergency Assistance Act*, President Obama declared that, as a result of the effects of Hurricane Sandy, a major disaster exists in the State of New York, retroactive to October 27, 2012. On October 31, 2012, HHS Secretary Sebelius declared that a public health emergency exists in the State of New York and authorized waivers and modifications under Section 1135 of the *Social Security Act* (the Act), retroactive to October 27, 2012.

On November 2, 2012, the Acting Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under Section 1812(f) of the *Social Security Act* for the entire State of New Jersey, retroactive to October 26, 2012. On October 31, 2012, the Acting Administrator of CMS authorized waivers under Section 1812(f) for the entire State of New York, retroactive to October 27, 2012.

These declarations alter certain Medicare requirements in order to assure that Medicare's Fee-For-Service (FFS) beneficiaries affected by this disaster will have timely access to needed health care services. See the Background section of this article for more details.

Background

Section 1135 and Section 1812(f) Waivers

As a result of the aforementioned declarations, CMS has instructed Medicare contractors as follows:

1. Change Request (CR) 6451 (Transmittal 1784, Publication 100-04) issued on July 31, 2009, applies to items and services furnished to Medicare beneficiaries within the State of New Jersey from October 26, 2012, for the duration of the emergency. CR6451 also applies to items and services furnished to Medicare beneficiaries within the State of New York from October 27, 2012, for the duration of the emergency. In accordance with CR6451, use of the "DR" condition code and the "CR" modifier are mandatory on claims for items and services for which Medicare payment is conditioned on the presence of a "formal waiver" including, but not necessarily limited to, waivers granted under either Section 1135 or Section 1812(f) of the Act.

2. Medicare FFS Questions & Answers (Q&As) posted on the CMS website are applicable for items and services furnished to Medicare beneficiaries within the States of New Jersey and New York. These Q&As are displayed in two files. The first listed file addresses policies and procedures that are applicable without any Section 1135 or other formal waiver. These policies are always applicable in any kind of emergency or disaster, including the current emergency in New York and New Jersey. The second file addresses policies and procedures that are applicable only with a Section1135 waiver or, when applicable, a Section 1812(f) waiver. These Q&As are effective October 26, 2012, for New Jersey and October 27, 2012, for New York. In both cases, the links below will open the most current document. The date included in the document filename will change as new information is added, or existing information revised.

    a) Q&As applicable without any Section 1135 or other formal waiver are available at **http://www.cms.gov/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf** on the CMS website; and

    b) Q&As applicable only with a Section 1135 waiver or, when applicable, a Section 1812(f) waiver, are available at **http://www.cms.gov/Emergency/downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf** on the CMS website.

Blanket Waivers Issued by CMS

Under the authority of Section 1135 (or, as noted below, Section 1812(f)), CMS has issued blanket waivers in the affected area of **New York and New Jersey**. Individual facilities do not need to apply for the following approved blanket waivers:

All Providers

- Bed Capacity: The states of New York and New Jersey are authorized to process certified bed increases for hospitals and nursing homes, per the request from the facility.
- CMS has suspended onsite survey activities (except for investigations of immediate jeopardy allegations) in areas impacted by the storm.

Skilled Nursing Facilities

- Waiver of 3-day prior hospitalization under Section 1812(f) for coverage of a Skilled Nursing Facility stay (Blanket waiver)
- 42 CFR 483.20: Timeframe requirements for Minimum Data Set assessments and transmission (Blanket waiver for all impacted facilities)

Home Health Agencies

- 42 CFR 484.20(c)(1): OASIS Transmission timeframes (Blanket waiver for all impacted agencies)
- 42 CFR 484.36(d)(2): Two Week Aide Supervision requirements by an RN (Blanket waiver for all impacted agencies)
- Home health agencies should monitor information posted at **http://www.cms.gov/Emergency** for updates on waivers.

Hospice

- 42 CFR 418.76: Supervision of Hospice Aides every 14 days by a registered nurse (Blanket waiver for all impacted agencies)
- Hospice agencies should monitor information posted at **http://www.cms.gov/Emergency** for updates on waivers related to hospice providers.

End Stage Renal Disease (ESRD)

In response to concerns about dialyzing ESRD patients on an outpatient basis, CMS clarified that when an ESRD patient who cannot obtain his or her regularly scheduled dialysis treatment at a certified ESRD facility and has a medical need to receive an unscheduled or emergency dialysis session in an outpatient hospital setting, the service is payable under the Outpatient Prospective Payment System (OPPS).

Disclosure of Health Insurance Claim Number (HICN) for Provider Billing Over the Telephone During a Public Health Emergency

During a public health emergency, CMS recognizes that a beneficiary may present to a Medicare provider without his or her HICN. Therefore, **under these circumstances only**, Medicare contractors may disclose the HICN to a provider, in order to bill Medicare when the provider gives four pieces of beneficiary identifying information. These may include: Social Security Number (SSN), date of birth, address on file, telephone number, effective date(s) of Medicare entitlement, and whether the beneficiary has Part A and/or Part B coverage.

Medicare contractors should still make every effort to obtain four pieces of identifying information, including the HICN, during a Public Health Emergency (PHE). However, if the HICN is not known, it may be any four pieces of identifying information. In situations where the provider is unable to provide four pieces of identifying information, the contractor should use professional judgment to determine whether or not the release of the HICN is appropriate under the circumstances.

In addition, the contractor must make every attempt to verify that the person requesting the HICN is the provider of service. The contractor should use the Provider Enrollment, Chain and Ownership System (PECOS) to verify the provider's SSN, date of birth, and Provider Transaction Access Number (PTAN). For organizational providers, the contractor should use PECOS to verify the name of the authorized or delegated official on file for the provider.

Additional Information

The Federal Emergency Management Agency (FEMA) website is available at **http://www.fema.gov/sandy** on the Internet. It contains information on special disaster assistance, including the availability of emergency shelters for those who are unable to remain in or return to their homes due to the disaster.

For assistance, New York providers may contact the New York State Department of Health's special emergency hotline number at **(866) 544-1303**. New Jersey providers may contact the New Jersey State Department of Health's special emergency hotline number at **(866) 234-0964**.

Additional CMS-specific information on Hurricane Sandy is available on the CMS Emergency web page at **http://www.cms.gov/Emergency** on the CMS website. This web page includes links to the following documents:

- Provider Survey and Certification Frequently Asked Questions (FAQs);
- Section 1135 Waiver Summary and Q&As;
- Medicare FFS Emergency Q&As (applicable without a Section 1135 or other formal waiver);
- Medicare FFS Emergency Q&As (applicable only with a Section 1135 or, when applicable, an 1812(f) waiver); and
- Health Emergency Declarations and Waivers.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Implementation of Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) Consolidated Billing Requirements for Daptomycin and a Clarification of Outlier Services for Calendar Year 2013 (MM7869) (SPE)

MLN Matters® Number: MM7869
Related CR Release Date: November 5, 2012
Related CR Transmittal #: R2588CP

Related Change Request (CR) #: CR 7869
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Provider Types Affected

This MLN Matters® Article for Change Request (CR) 7869 is intended for physicians, other providers, and suppliers who submit 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 End-Stage Renal Disease (ESRD) services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7869 which provides an update to the ESRD PPS for Calendar Year (CY) 2013, including the billing requirements for Daptomycin, and the CR clarifies Outlier Services for Calendar Year 2013.

Background

The *Medicare Improvements for Patients and Providers Act* (MIPPA; Section 153(b); see **http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf** on the Internet) amends the *Social Security Act* (section 1881(b)(12); see **http://www.ssa.gov/OP_Home/ssact/title18/1881.htm** on the Internet) by requiring the implementation of an End Stage Renal Disease (ESRD) bundled Prospective Payment System (PPS) effective January 1, 2011.

The ESRD PPS was implemented by CR7064 (Transmittal 2134, End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services). See the MLN Matters® article, MM7064, corresponding to CR7064 at **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

ESRD Claims Reporting ESRD-Related Drugs and Biologicals

The "*Medicare Benefit Policy Manual*" (Chapter 11, Section 30.4.1; see **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf** on the CMS website) lists the drugs and fluids that were included under the composite payment system, which are heparin, antiarrythmics, protamine, local anesthetics, apresoline, dopamine, insulin, lidocaine, mannitol, saline, pressors, heparin antidotes, benadryl, hydralazine, lanoxin, solu-cortef, glucose, antihypertensives, antihistamines, dextrose, inderal, levophed, and verapamil.

The manual also explicitly states, "… drugs used in the dialysis procedure are covered under the facility's composite rate and may not be billed separately. Drugs that are used as a substitute for any of these items, or are used to accomplish the same effect, are also covered under the composite rate." Data analysis of 2011 ESRD claims indicate that ESRD facilities are reporting composite rate drugs resulting in duplicate payment to those ESRD facilities that are receiving a blended payment under the transition period and inappropriate inclusion in the outlier calculation (discussed below).

In addition, in the Calendar Year (CY) 2012 ESRD PPS final rule (see **http://www.gpo.gov/fdsys/pkg/FR-2011-11-10/pdf/2011-28606.pdf** on the Internet) and in CR7617 (Transmittal 150,Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2012), CMS discussed alteplase and other thrombolytic drugs. CMS indicated that a clinical review of the 2007 claims used to develop the ESRD PPS revealed that ESRD facilities routinely used alteplase and other thrombolytic drugs for access management purposes. CMS also indicated that because these drugs are used to accomplish the same effect (that is, vascular access management) as a composite rate drug, they are also considered to be composite rate drugs and, therefore, should not be reported on the ESRD claim. In CR7617, CMS removed alteplase and other thrombolytic drugs from the outlier calculation but CMS did not implement edits to prevent separate payment to the ESRD facilities that are receiving a blended payment during the transition. See the MLN Matters® article, MM7617, corresponding to CR7617, at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7617.pdf** on the CMS website. For CY 2013, separate payment for alteplase and other thrombolytics will not be paid separately under the composite rate portion of the blended payment for ESRD facilities receiving a blended payment during the transition.

ESRD-Related Drugs and Biologicals that Qualify as Outlier Services

Medicare regulations at 42 CFR §413.237(a)(1)(i) (see **http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr413_main_02.tpl** on the Internet) provide that ESRD outlier services are those ESRD-related services that were or would have been considered separately billable under Medicare Part B for renal dialysis services furnished prior to January 1, 2011. Therefore, items and services that would have been included under the composite rate do not qualify as an outlier services.

ESRD Claims Reporting Daptomycin

CR7064 provided ESRD consolidated billing requirements for certain Part B services included in the ESRD PPS bundled payment.) See the MLN Matters® article, MM7064, corresponding to CR7064 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf** on the CMS website.) All drugs reported on the ESRD facility claim that do not have an AY modifier are considered included in the ESRD PPS. The list of drugs and biologicals for consolidated billing are designated as always ESRD-related and therefore separate payment is not made to ESRD facilities. Daptomycin is included on the consolidated billing list.

Revision to ESRD Claims Reporting Daptomycin, Effective January 1, 2013

ESRD facilities have the ability to receive separate payment for Healthcare Common Procedure Coding System (HCPCS) code J0878 Injection, Daptomycin, 1 mg furnished on or after January 1, 2013, by placing the AY modifier on the 72X claim when Daptomycin is furnished to an ESRD patient that is not for the treatment of ESRD. The ESRD facility is required to indicate (in accordance with diagnosis coding guidelines) the diagnosis code for which Daptomycin is indicated.

Revision to ESRD Claims Reporting ESRD-Related Drugs and Biologicals, Effective January 1, 2013

Composite rate items and services should not be reported on the ESRD facility claim. Because ESRD facilities are continuing to inappropriately report composite rate drugs, CMS developed a list of certain drugs and biologicals based on the 2011 claims data that are considered to be composite rate drugs (see attachment A of CR7869, which is at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2588CP.pdf** on the CMS website). ESRD facilities that are receiving reimbursement under the transition and have been inappropriately reporting drugs and biologicals considered to be in the composite rate will no longer be separately paid in the composite rate portion of the blended payment for these drugs effective January 1, 2013. In addition, because these ESRD-related drugs are considered to be in the composite rate they are also considered to be always ESRD-related. Therefore, CMS is updating the list of items and services that, effective January 1, 2013, are subject to consolidated billing requirements which can be found at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/Consolidated_Billing.html** on the CMS website. ESRD-related drugs and biologicals located on this list are not eligible to be paid separately with the AY modifier.

The list of ESRD-related drugs in attachment A of CR7869 is not an all-inclusive list, and ESRD facilities should not be reporting any composite rate items and services on the ESRD claim. ESRD facilities should not change treatment behaviors to receive separate payment. For example drugs and biologicals used for the purpose of access management should not be reported on the claim because, in accordance with the "*Medicare Benefit Policy Manual*" (Chapter 11, Section 30.4.1; see **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c11.pdf** on the CMS website) those drugs are considered to be composite rate drugs. CMS is continuing to monitor the claims data for drug utilization.

The list of ESRD-related drugs and biologicals on attachment B of CR7869 is not an all-inclusive list of the drugs and biologicals that are included in the ESRD PPS. For example, any anti-infective drugs that are used for access management are included in the ESRD PPS. Attachment B has been updated to reflect 2011 claims data. However, any drug or biological (even if not one of the categories in attachment B) that is used for the treatment of ESRD (that is, ESRD-related) is included in the ESRD PPS and is not separately paid.

Clarification of ESRD-Related Drugs and Biologicals that Qualify as Outlier Services, Effective January 1, 2013

Because ESRD facilities are continuing to inappropriately report composite rate drugs, composite rate drugs are incorrectly being included in the outlier calculation. Therefore, we developed a list of drugs and biologicals (attachment A) from the 2011 claims data that are considered to be composite rate drugs. This is not an all-inclusive list and ESRD facilities should not be reporting composite rate items and services on the ESRD claim. The ESRD-related drugs and biologicals listed on attachment A will not qualify as outlier services.

Peginesatide, Effective January 1, 2013

Peginesatide is a new Erythropoiesis-Stimulating Agent (ESA) drug approved for the treatment of anemia in dialysis patients. Peginesatide has been assigned a permanent HCPCS code of J0890. This permanent code replaces the temporary code issued Q2047. Peginesatide is subject to ESRD consolidated billing requirements. The drug description indicates use while on dialysis, therefore, it would be inappropriate to bill J0890 with modifier AY. The consolidated billing requirement may not be overridden with the use of the AY modifier.

Additional Information

The official instruction, CR7869, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2588CP.pdf** on the CMS website.

If you have any questions, please contact your carriers, DME MACs, FIs, or A/B MACs at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

MLN Matters® article, MM7064 "*End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services*" found here **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7064.pdf** on the CMS website.

MLN Matters® article, MM7617 "*Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2012*" found here **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7617.pdf** on the CMS website.

Importance of Preparing/Maintaining Legible Medical Records (SE1237) (GEN)

MLN Matters® Number: SE1237
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Article Special Edition (SE) is intended for physicians and other providers who document treatment for Medicare beneficiaries and/or submit claims for Medicare Fee-For-Service (FFS) reimbursement.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is publishing this article to highlight the importance of legible documentation in avoiding claim denials. This SE1237 article is informational only and does not alter existing Medicare policy, and does not introduce new policy.

Background

Many claim denials occur because the providers or suppliers do not submit sufficient documentation to support the service or supply billed. Frequently, this documentation is insufficient to demonstrate medical necessity. In accordance with Section 1862(a)(1)(A) of the *Social Security Act*, CMS must deny an item or service if it is not reasonable and necessary.(See item 1 in the "References" section below.) When determining the medical necessity of the item or service billed, Medicare's review contractors must rely on the medical documentation submitted by the provider in support of a given claim. Therefore, legibility of clinical notes and other supporting documentation is critical to avoid Medicare FFS claim payment denials. (See item 2 in the "References" section below.)

Key Points

General Principles of Medical Record Documentation (See items 3,4,5 in the "References" section below.) - Be Aware

The general principles of medical record documentation to support a service or supply billed for Medicare payment includes the following (as applicable to the specific setting/encounter):

1. **Medical records should be complete and legible; and**
2. **Medical records should include the legible identity of the provider and the date of service.**

Amendments, Corrections and Delayed Entries in Medical Documentation (See item 6 in the "References" section below.)

Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles:

1. Clearly and permanently identify any amendments, corrections or addenda.
2. Clearly indicate the date and author of any amendments, corrections, or addenda.
3. Clearly identify all original content (do not delete).

Medicare Signature Requirements (See item 7 in the "References" section below.)

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature.

- If the signature is illegible or missing from the medical documentation (other than an order), the review contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, the review contractor shall disregard the order during the review of the claim (i.e., the reviewer will proceed as if the order was not received). Signature attestations are not allowable for orders.

References

1. See the testimony of Thursday, July 15, 2010 to the United States Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and Internet. "Preventing and Recovering Medicare Payment Errors" at **http://www.hhs.gov/asl/testify/2010/07/t20100715a.html** on the CMS website.

2. See the CMS "*Medicare Program Integrity Manual*" Section 3.6.2.1 - Coverage Determinations at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf** on the CMS website.

3. See the "*Medicare Benefit Policy Manual*" Chapter 2, Section 30, at **http://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/Downloads/bp102c02.pdf** on the CMS website.

4. See Change Request (CR) 2520, Provider Education Article, at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/AB03037.pdf** on the CMS website.

5. See the MLN Matters® Special Edition article, SE1027, entitles "*Recovery Audit Contractor (RAC) Demonstration High-Risk Medical Necessity Vulnerabilities for Inpatient Hospitals*" at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1027.pdf** on the CMS website.

6. See the "*Medicare Program Integrity Manual*" Section 3.3.2.5 - Amendments, Corrections and Delayed Entries in Medical Documentation at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf** on the CMS website.

7. See the "*Medicare Program Integrity Manual*" Section 3.3.2.4 - Signature Requirements **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf** on the CMS website.

Additional Information

If you have any questions, please contact your carrier, FI, DME MAC or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

For additional information and educational materials related to provider compliance, visit **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html** on the CMS website.

To review specific rules for signature guidelines for medical review purposes and language for E-Prescribing you may go to **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6698.pdf** on the CMS website.

Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers (SE1201) (GEN)

MLN Matters® Number: SE1201 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 September 19, 2012, to add a statement at the top of page 3 regarding Optometrists. The article also now contains a reference to MLN Matters® Article SE1221 and all Web addresses have been updated. All other information remains the same.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers and suppliers (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.

Provider Action Needed

Impact to You

Medicare will only pay for items or services for Medicare beneficiaries that have been ordered by a physician or eligible professional who is enrolled in Medicare and their individual National Provider Identifier (NPI) has been provided on the claim. The ordering provider or supplier (physician or eligible professional) must also be enrolled with a specialty type that is eligible (per Medicare statute and regulation) to order and refer those particular items or services.

What You Need to Know

Make sure you follow Medicare directives when providing services ordered for the services outlined below.

What You Need to Do

You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide.

Background

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Portable X-Ray services may only be ordered by a Doctor of Medicine or Doctor of Osteopathy. Portable X-Ray services ordered by any other practitioners will be denied.
- Optometrists may only order and refer laboratory and X-Ray services.

MLN Matters® Special Edition Articles SE1011 and SE1221 provide further details about edits on the ordering/referring provider information on claims. SE1011 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf** and SE1212 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1221.pdf** on the CMS website.

Additional Information

For more information about the Medicare enrollment process, visit **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html** or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf** on the CMS website.

The Medicare Learning Network® (MLN) fact sheet titled, "*Medicare Enrollment Guidelines for Ordering/Referring Provider*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf** on the CMS website.

MLN Matters® Article MM7097, "*Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf** on the CMS website.

MLN Matters® Article MM6417, "*Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf** on the CMS website.

MLN Matters® Article MM6421, "*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)*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf** on the CMS website.

MLN Matters® Article MM6129, "*New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf** on the CMS website.

January 2013 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM8116) (DRU)

MLN Matters® Number: MM8116
Related CR Release Date: October 26, 2012
Related CR Transmittal #: R2568CP

Related Change Request (CR) #: CR 8116
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Provider Types Affected

This MLN Matters® Article is intended 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 Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

Medicare will use the January 2013 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2013, with dates of service from January 1, 2013, through March 31, 2013.

What You Need to Know

Change Request (CR) 8116, from which this article is taken, instructs your Medicare Contractors to download and implement the January 2013 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers

for Medicare & Medicaid Services (CMS), to also download and implement the revised January 2013, October 2012, July 2012, April 2012, and January 2012 files.

What You Need to Do

Please ensure that your staffs are aware of this January 2013 quarterly update. Contractors will not search and adjust claims that have already been processed unless brought to their attention.

Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply 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 that can be located in the "*Medicare Claims Processing Manual*" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf** on the CMS website.)

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

Files	Effective for Dates of Service
January 2013 ASP and ASP NOC	January 1, 2013, through March 31, 2013
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012

Additional Information

You can find the official instruction, CR8116, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2568CP.pdf** 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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Medicare DMEPOS Competitive Bidding Program: Quick Reference Article (SE1244) (GEN)

MLN Matters® Number: SE1244
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is informational in nature. It is intended to be a quick reference tool for all health care professionals who order or refer patients for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) in a Competitive Bidding Area (CBA).

Background

The Round 1 Rebid of the Medicare DMEPOS Competitive Bidding Program (The Program) was successfully implemented in nine areas on January 1, 2011. Round 2 of The Program is targeted to go into effect in 91 Metropolitan Statistical Areas (MSAs) on July 1, 2013. Medicare will also be implementing a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program 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.

When a round of The Program becomes effective, beneficiaries with Original Medicare who obtain competitively bid items in CBAs must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. Referral agents located in CBAs

who prescribe DMEPOS for Medicare beneficiaries or refer beneficiaries to specific suppliers should be aware of which suppliers in the area are contract suppliers. The Centers for Medicare & Medicaid Services (CMS) plans to announce the contract suppliers for Round 2 and the national mail order program in the spring of 2013.

About This Article

This article is designed as a quick reference tool that provides referral agents with a list of important web links and phone numbers to find information on The Program. The information found at these sources will greatly assist referral agents in locating information that will assist them in obtaining DMEPOS items and services for Medicare beneficiaries. For purposes of The Program, referral agents include such entities as Medicare enrolled providers, physicians, treating practitioners, discharge planners, social workers, disability/disease-based organizations, and pharmacists who refer beneficiaries for services in a CBA.

Referral agents play a critical role in helping beneficiaries select DMEPOS suppliers that can meet the beneficiaries' needs and meet the requirements of the program. A beneficiary's first contact with The Program may be at the point when he or she receives a prescription for a competitively bid item. If the beneficiary resides in a CBA or is visiting a CBA in which he or she needs to obtain a competitively bid item, he or she may need to be directed to a contract supplier.

Where Do I Go to Learn More About the Medicare DMEPOS Competitive Bidding Program?

The CMS webpage on The Program (**http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html**) provides links to the latest news, press releases, announcements and fact sheets. A link to the Round 2/National Mail Order timeline can also be found on this webpage.

Partnering with CMS is a key to helping people with Medicare maximize their benefits. Beyond extending the reach of these important benefits to people who need them, a partnership helps you leverage resources by fostering relationships with other CMS partners, keeps you informed, and provides you with expert training, educational materials, tools such as this toolkit at **http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html**, research, and a connection to CMS' 10 regional offices, where you may access personalized local assistance.

E-Mail Updates for Referral Agents

In the coming months leading up to the start of The Program, CMS will send out more information that will be helpful for referral agents and guide them through the changes that the new program brings.

In light of the important role that referral agents serve, CMS has adopted the use of a new email update to better communicate the various aspects of The Program and to ensure that official information is released and received by referral agents as quickly as possible. CMS encourages all referral agents to sign up for this new email update to ensure they receive the most accurate and timely information regarding The Program.

To ensure you give Medicare patients correct DMEPOS information, sign up for the email updates for referral agents (**https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7814**).

How Do I Know If a Medicare Beneficiary Resides in a Competitive Bidding Area?

The Competitive Bidding Implementation Contactor (CBIC) provides a tool at **http://www.dmecompetitivebid.com** to find a CBA on its website. To determine if a beneficiary resides in a CBA, click on the "Find a CBA" tab and enter the ZIP CODE of the beneficiary's permanent residence on file with the Social Security Administration (SSA).

The tool will indicate whether the ZIP CODE is within a CBA or not.

How Do I Find a Medicare Contract Supplier for a Medicare Beneficiary in a CBA?

The Medicare.gov website (**http://www.medicare.gov/default.aspx**) provides a Supplier Directory tool under the "Resource Locator" tab for finding a Medicare contract supplier to provide certain durable medical equipment in the Medicare DMEPOS Competitive Bidding Program where the beneficiary resides. Once the contract suppliers have been announced, the Supplier Directory tool will indicate whether the beneficiary is affected by the Medicare Competitive Bidding program based on the beneficiary's ZIP CODE and the particular DMEPOS needed.

Customer service representatives at **1-800-MEDICARE (1-800-633-4227)** can also assist beneficiaries in finding a contract supplier. **TTY users should call 1-877-486-2048**.

How Do I Know What DMEPOS Items and Services Are Competitively Bid Items in the Program?

Product categories are groupings of related items that are used to treat a similar medical condition. A list of the product categories for Round 2 can be found by visiting **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Product_Categories_and_Items.html** on the CMS website.

The CBIC provides a tool to identify specific items within a product category by Healthcare Common Procedure Coding System (HCPCS) code at **http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Product%20Categories** on its website.

Medicare Guidance Regarding Meningitis Outbreak (SE1246) (GEN)

MLN Matters® Number: SE1246
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: Not Applicable
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

What You Need to Know

Impact to You

The Centers for Medicare & Medicaid Services (CMS) is providing direction to Medicare contractors based on the Centers for Disease Control and Prevention's (CDC) interim treatment guidance for Central Nervous System (CNS). This guidance is also related to parameningeal infections and septic arthritis associated with contaminated steroid products produced by the New England Compounding Center (NECC). This guidance is available on the CDC website at **http://www.cdc.gov/hai/outbreaks/clinicians/index.html** on the Internet.

What You Need to Know

The CDC recommends diagnostic and therapeutic activities for symptomatic patients. Therefore, CMS believes that, aside from oral drugs, items and services to diagnose and treat patients who have received contaminated medications qualify for the Medicare Part A or Part B benefit.

CMS urges all Medicare contractors to review the CDC website at **http://www.cdc.gov/hai/outbreaks/clinicians/faq_meningitis_outbreak.html** regularly for updates and specific actions they should take to ensure timely access to CDC recommended items and services.

Due to the severity of this situation, CMS advises providers that Medicare contractors are expected to expedite all coverage determination requests for these items and services to include antifungal medication.

The CDC has identified the following states as having received potentially-contaminated steroid products:

California	Michigan	Pennsylvania
Connecticut	Minnesota	Rhode Island
Florida	Nevada	South Carolina
Georgia	New Hampshire	Tennessee
Idaho	New Jersey	Texas
Illinois	New York	Virginia
Indiana	North Carolina	West Virginia
Maryland	Ohio	

While clinics in these states received contaminated products, patients in additional states may be affected. Check the CDC's Multistate Fungal Meningitis Outbreak Investigation web page regularly for the latest news and information about the outbreak. The website is available at: **http://www.cdc.gov/hai/outbreaks/clinicians/faq_meningitis_outbreak.html** on the Internet.

What You Need to Do

Make sure that your medical and billing staffs are aware of this guidance.

Additional Information

If you have any questions, please contact your FI, carrier, DME MAC or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

New Informational Unsolicited Response (IUR) Process to Identify Previously Paid Claims for Services Furnished to Incarcerated Medicare Beneficiaries (MM8007) (GEN)

MLN Matters® Number: MM8007
Related CR Release Date: November 1, 2012
Related CR Transmittal #: R1134OTN

Related Change Request (CR) #: CR 8007
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and A/B MACs) for services provided to incarcerated Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8007, which informs Medicare contractors about the creation of a new Informational Unsolicited Response (IUR) process to identify and perform retroactive adjustments on any previously paid claims which may have been processed and paid erroneously during periods when the beneficiary data in the Enrollment Database (EDB) did not reflect the fact that the beneficiary was incarcerated.

Medicare will generally not pay for medical items and services furnished to a beneficiary who was incarcerated on the date of service that the items and services were furnished. Medicare is creating a new IUR process in its systems to identify previously paid claims that contain Dates of Service (DOS) that partially or fully overlap a period when the beneficiary was incarcerated (exceptions noted below). The IUR process will be initiated:

- When there is an automatic update to the beneficiary's record that indicates a change to the beneficiary's "incarcerated" start date or end date, or
- When there is a manual update to the beneficiary's record that indicates a change to the beneficiary's "incarcerated" start date or end date.

Upon receiving the IUR, Medicare contractors will initiate overpayment recovery procedures to recoup any Medicare Part A and Part B payments.

Make sure that your billing staffs are aware of this update.

Background

Under Sections 1862(a)(2) and (3) of the *Social Security Act*, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Accordingly, the Centers for Medicare & Medicaid Services (CMS) presumes that a State or local government entity that has custody of a Medicare

beneficiary under a penal statute has a financial obligation to pay for the cost of medical services and Medicare will generally not reimburse claims for services rendered to a beneficiary while he/she is in such custody.

Regulations at 42 Code of Federal Regulations (CFR) Section 411.4(b) state that:

> "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Federal benefit entitlement information is provided to CMS by the Social Security Administration (SSA) on a daily basis. When the SSA learns of a beneficiary's incarceration, the beneficiary's record in the EDB is updated to reflect that fact and the effective date (or "Start date") of the incarceration.

CMS Transmittal AB-02-164, CR2022, issued on November 8, 2002, implemented a Medicare systems edit to reject services billed to Medicare when information in the EDB indicates that, on the date of service, the beneficiary was incarcerated. Upon receipt of this rejection, Medicare contractors are instructed to deny the claims. CR4352, which manualized CR2022, may be viewed at are instructed to deny the claims. CR4352, which manualized CR2022, may be viewed at are instructed to deny the claims. CR4352, which manualized CR2022, may be viewed at
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R883CP.pdf on the CMS website.

OIG Finding of Vulnerability

The Office of Inspector General (OIG) has recently identified a vulnerability where there may be, in some instances, a period of time between when the beneficiary is incarcerated and when the SSA learns of this status and updates its records (and Medicare files are subsequently updated). During this time, it is possible that Medicare Fee-For-Service (FFS) claims for services would be paid erroneously because the beneficiary's entitlement data in the EDB is not up-to-date when the claims are adjudicated.

Creation of IUR to Remedy Vulnerability

CMS has identified the IUR process as a means to mitigate this vulnerability. An IUR identifies a claim that appears to need to be adjusted by a Medicare contractor. The contractor, when appropriate, initiates overpayment recovery procedures to retract Part A or Part B payment.

Therefore, the intent of CR8007 is to create a new IUR process to identify and perform retroactive adjustments on any previously paid claims that may have been processed and paid erroneously during periods when the beneficiary data in the EDB did not reflect the fact that the beneficiary was incarcerated.

Additional Information

The official instruction, CR8007, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1134OTN.pdf** on the CMS website. If you have any questions, please contact your FI, RHHI, carrier, DME MAC, or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

New Informational Unsolicited Response (IUR) Process to Identify Previously Paid Claims for Services Furnished to Medicare Beneficiaries Classified as "Unlawfully Present" in the United States (MM8009) (GEN)

MLN Matters® Number: MM8009
Related CR Release Date: November 1, 2012
Related CR Transmittal #: R1133OTN

Related Change Request (CR) #: CR 8009
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

Provider Types Affected

This MLN Matters® Article is intended 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 Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What you Need to Know

This article is based on Change Request (CR) 8009, which informs Medicare contractors about the creation of a new Informational Unsolicited Response (IUR) process to identify and perform retroactive adjustments on any previously paid claims that contain dates of service (DOS) that partially or fully overlap a period when the beneficiary was unlawfully present in the United States. The IUR process shall be initiated:

- When there is an automatic update to the beneficiary's record in CWF via an EDB transaction which indicates a change to the beneficiary's "unlawfully present" start date or end date, or
- When there is a manual update to the beneficiary's record in CWF which indicates a change to the beneficiary's "unlawfully present" start date or end date.

Upon receiving the IUR, Medicare contractors will initiate overpayment recovery procedures to recoup any Medicare Part A and Part B payments.

Background

Section 401 of the *Personal Responsibility and Work Opportunity Reconciliation Act* of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving Federal benefits, including Medicare benefits. Consistent with this legislation, Section 10.1.4.8 of Chapter 1 of the "*Medicare Claims Processing Manual*" (**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf**) states that: "Medicare payment may not be made for items and services furnished to an alien beneficiary who was not lawfully present in the United States on the date of service."

Federal benefit entitlement information is provided to the Centers for Medicare & Medicaid Services (CMS) by the Social Security Administration (SSA) on a daily basis. Such information is used in the adjudication of claims for healthcare services provided to Medicare beneficiaries. When the SSA learns of a beneficiary's status as "unlawfully present" in the United States, the beneficiary's record in Medicare's files is updated to reflect that fact and the effective date of that status.

CMS Transmittal AB-03-115, Change Request (CR) 2825, issued on August 1, 2003, implemented an edit in Medicare systems to reject services billed to Medicare when information in its files indicates that, on the date of service, the beneficiary was not lawfully present in the United States. Upon receipt of this rejection, Medicare contractors are instructed to deny the claim or claims.

OIG Finding of Vulnerability

The Office of Inspector General (OIG) has identified a vulnerability where there may be, in some instances, a period of time between when the beneficiary is deemed to be unlawfully present in the United States and when the SSA learns of this status and updates its records (and the Medicare files are subsequently updated). During this time, it's possible that Medicare Fee-For-Service (FFS) claims for services would be paid erroneously because the beneficiary's entitlement data is not up-to-date when the claims are adjudicated.

Creation of IUR to Remedy Vulnerability

CMS has identified a process to mitigate this vulnerability. An IUR identifies a claim that appears to need to be adjusted by a Medicare contractor. The contractor, when appropriate, initiates overpayment recovery procedures to retract Part A or Part B payment. Therefore, the intent of CR 8009 is to create a new process to identify and perform retroactive adjustments on any previously paid

claims which may have been paid erroneously during periods when the beneficiary data in Medicare's files did not reflect the fact that the beneficiary was unlawfully present in the United States.

Additional Information

You can find the official instruction, CR8009, issued to your Medicare Carrier, FI, DME MAC, RHHI, or A/B MAC by visiting **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1133OTN.pdf** on the CMS website. If you have any questions, please contact your Medicare Carrier, FI, DME MAC, RHHI, or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

New Place of Service (POS) Code for Place of Employment/Worksite (MM8125) (GEN)

MLN Matters® Number: MM8125
Related CR Release Date: November 30, 2012
Related CR Transmittal #: R2602CP
Related Change Request (CR) #: CR 8125
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Medicare carriers, Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for occupational-related medical, therapeutic, or rehabilitative services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8125, from which this article is taken, updates the current Place of Service (POS) code set to add a new code: 18 - Place of Employment/Worksite.

Background

CR8125, from which this article is taken, updates the current Medicare POS code set to add a new code: 18 - Place of Employment/Worksite; described as: "a location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic, or rehabilitative services to the individual."

The Centers for Medicare & Medicaid Services (CMS) is establishing this POS code because:

1. Industry entities (other than Medicare) have identified a need to establish the delivery of occupational-related medical and rehabilitation services in the work place in order to: A) reduce employee time lost from work; and B) enable therapists to evaluate the work environment and provide rehabilitation services that are focused on returning the individual to their pre-injury state in a way that maximizes function in the workplace environment and reduces employee time lost.
2. As a *Health Insurance Portability and Accountability Act* of 1996 (HIPAA) covered entity, Medicare must comply with its standards and their implementation guides that are adopted by regulation. Specifically, the currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12 837 (Professional Health Care Claim) standards requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that CMS maintains.

Therefore, while it has not identified an inherent need for this new code; as a payer, Medicare must be able to recognize any code from the POS code set that appears on the HIPAA standard claim transaction.

Additional Information

The official instruction, CR8125, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2602CP.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Ordering and Certifying Documentation - Maintenance Requirements (MM7890) (GEN)

MLN Matters® Number: MM7890
Related CR Release Date: August 31, 2012
Related CR Transmittal #: R431PI

Related Change Request (CR) #: CR 7890
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

This MLN Matters® Article is intended for physicians, non-physician practitioners, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers and Home Health Agencies (HHAs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.

Provider Action Needed

Impact to You

This article, based on Change Request (CR) 7890, informs you of instructions to Medicare contractors regarding the implementation of ordering and certifying documentation and maintenance requirements found in 42 Code of Federal Regulations (CFR) 424.516(f).

What You Need to Know

A provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to:

- Maintain documentation for 7 years from the date of service, and
- Provide access to that documentation upon the request of the Centers for Medicare & Medicaid Services (CMS) or a Medicare contractor.

A physician who orders/certifies home health services and a physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to:

- Maintain the documentation for 7 years from the date of service, and
- Provide access to that documentation upon the request of CMS or a Medicare contractor.

If the provider, supplier, physician or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

What You Need to Do

Review the description of documentation to be maintained in the Background section below. Make sure that your billing staffs are aware of these requirements for documentation.

Background

Under 42 CFR 424.516(f)(1), a provider or supplier that furnishes covered ordered items of DMEPOS, clinical laboratory, imaging services, or covered ordered/certified home health services is required to (1) maintain documentation (see next paragraph) for 7 years from the date of service, and (2) provide access to that documentation upon the request of CMS or a Medicare contractor.

The documentation to be maintained includes written and electronic documents (including the National Provider Identifier (NPI) of the physician who ordered/certified the home health services and the NPI of the physician or, when permitted, other eligible professional who ordered items of DMEPOS or clinical laboratory or imaging services) relating to written orders and certifications and requests for payments for items of DMEPOS and clinical laboratory, imaging, and home health services.

In addition, under 424.516(f)(2), a physician who orders/certifies home health services and the physician or, when permitted, other eligible professional, who orders items of DMEPOS or clinical laboratory or imaging services is required to maintain the documentation described in the previous paragraph for 7 years from the date of service and to provide access to that documentation pursuant to a CMS or Medicare contractor request.

If the provider, supplier, physician, or eligible professional (as applicable) fails to maintain this documentation or to furnish this documentation upon request, the contractor may revoke the party's Medicare billing privileges under 42 CFR 424.535(a)(10).

The CMS policy states that, absent a CMS directive to the contrary, the Medicare contractor will request the documentation described above if it has reason to believe that the provider, supplier, physician or eligible professional (hereinafter collectively referred to as "provider") is not maintaining the documentation in accordance with Section 424.516(f)(1) or (2).

Examples of when a request might be appropriate include, but are not limited to, the following:

- The contractor has detected an unusually high number of denied claims involving the provider, or the Fraud Prevention System has otherwise generated an alert with respect to the provider.
- The provider has been the subject of a recent Zone Program Integrity Contractor referral.
- The provider maintains an elevated surety bond amount.

If a provider fails to respond to a letter request for documentation within 30 days of the Medicare contractor's request, the contractor may revoke the provider's Medicare billing privileges and impose a 1-year re-enrollment bar.

Additional Information

The official instruction, CR7890 issued to your carrier, FI, or A/B MAC regarding this change may be viewed **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R431PI.pdf** on the CMS website. If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Partial Code Freeze Prior to ICD-10 Implementation (SE1240) (GEN)

MLN Matters® Number: SE1240
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

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

What You Need to Know

At a meeting on September 14, 2011, the ICD-9-CM Coordination & Maintenance (C&M) Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10 which would end one year after the implementation of ICD-10. The implementation of ICD-10 was delayed from October 1, 2013 to October 1, 2014 by final rule CMS-0040-F issued on August 24, 2012. This final rule is available at **http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html** on the Centers for Medicare & Medicaid Services (CMS) website.

There was considerable support for this partial freeze. The partial freeze will be implemented as follows:

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012 and October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.

- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
- On October 1, 2015, regular updates to ICD-10 will begin.

The ICD-9-CM Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze. At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2015 once the partial freeze has ended.

The code freeze was initially discussed at the September 15, 2010, meeting of the committee. To view the transcript of that meeting, go to: **http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html** on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the '091510_Morning_Transcript' file. This section appears on page 4 of the 78-page document.

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

Additional Information

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

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

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

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

- **See MLN Matters® Special Edition Article, SE1239**, at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf** for an overview of what is needed to implement ICD-10.

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

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

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

Phase 2 of Ordering/Referring Requirement (SE1221) (GEN)

MLN Matters® Number: SE1221
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 September 17, 2012, to remove the word "Certified" from in front of Clinical Nurse Specialist on Page 3. All other information remains the same.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and 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 (including Portable X-Ray services) and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A Home Health Agency (HHA) services who submit claims to RHHIs, Fiscal Intermediaries (who still maintain an HHA workload), and Part A/B MACs.

Provider Action Needed

Impact to You

CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the Ordering/Referring Provider edits. These edits ensure that physicians and others who are eligible to order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60 day advanced notice prior to turning on the Ordering/Referring edits. CMS does not have a date at this time.

What You Need to Know

CMS shall authorize A/B MACs and DME MACs to begin editing Medicare claims with Phase 2 Ordering/Referring edits. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral from a provider who does not have a Medicare enrollment record.

What You Need to Do

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, 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-855O).

Background

The *Social Security Act* (the Act) requires that all physicians and non-physician practitioners be uniquely identified for all claims for services that are ordered or referred. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the National Provider Identifier (NPI).

CMS began expanding the claims editing to meet the Act's requirements for ordering and referring providers as follows:

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 is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

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,
- Clinical Nurse Specialist,
- Nurse Practitioner,
- Clinical Psychologist,
- Interns, Residents, and Fellows
- Certified Nurse Midwife, and
- Clinical Social Worker.

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. The informational messages are identified below:

For Part B providers and suppliers who submit claims to carriers:

N264	Missing/incomplete/invalid ordering physician provider name
N265	Missing/incomplete/invalid ordering physician primary identifier

For adjusted claims CARC code 45 along with RARC codes N264 and N265 will be used.

DME suppliers who submit claims to carriers (applicable to 5010 edits):

N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future

For Part A HHA providers who order and refer, the claims system shall initially process the claim and add the following remark message:

N272	Missing/incomplete/invalid other payer attending provider identifier

For adjusted claims the CARC code 16 and/or the RARC code N272 shall be used.

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: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. 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, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

254D	Referring/Ordering Provider Not Allowed To Refer
255D	Referring/Ordering Provider Mismatch
289D	Referring/Ordering Provider NPI Required

CARC code 16 and/or the RARC code N264 and N265 shall be used for denied or adjusted claims. Below are the denial edits for Part A HHA providers who submit claims:

37236 - This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from EPCOS or the specialty code is not a valid eligible code
37237 - This reason code will assign when:	• The statement "From" date on the claim is on or after the date the phase 2 edits are turned on. • The type of bill is '32' or '33' • The type of bill frequency code is '7' or 'F-P' • Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code

CMS published the final rule, CMS-6010-F, RIN 0938-AQ01, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements," on April 24, 2012, permitting Phase 2 edits to be implemented.

CMS will announce the date via an updated article when it shall authorize Part A/B and DME MACs and Part A RHHIs to implement Phase 2 edits.

Additional Information

A note on terminology: Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred or certified an item or service reported in that claim. CMS has used this term on its website and in educational products. The final rule uses technically correct terms: 1) a provider "orders" non physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services for a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

For more information about the Medicare enrollment process, visit **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html**, or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf** on the CMS website.

The Medicare Learning Network® fact sheet, "Medicare Enrollment Guidelines for Ordering/Referring Providers" provides information about the requirements for eligible ordering/referring providers and is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf** on the CMS website.

You may find the following articles helpful in understanding this matter:

- MLN Matters® Article MM6417, "*Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs),*" is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6417.pdf** on the CMS website.

- MLN Matters® Article MM6421, "*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),*" is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf** on the CMS website.

- MLN Matters® Article MM6856, "*Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)*", is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf** on the CMS website.

- MLN Matters® Article MM7097, "*Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7097.pdf** on the CMS website.

- MLN Matters® Article MM6129, "*New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services*," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6129.pdf** on the CMS website.

- MLN Matters® Special Edition Article SE1011, "*Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696),*" is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf** on the CMS website.

- MLN Matters® Article Special Edition Article SE1201 "*Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers*" is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf** on the CMS website.

- MLN Matters® Special Edition Article SE1208, "*855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals*," is available at **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1208.pdf** on the CMS website.

If you have any questions, please contact your carrier, Part A/B MAC, RHHI, Fiscal Intermediary, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Be sure to visit the "What's New" section of our Web site at http://www.medicarenhic.com/dme/dme_whats_new.shtml for the latest information and updates regarding the Medicare program and DME MAC A

Quarterly Update to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) (MM7858) (SPE)

MLN Matters® Number: MM7858 Revised
Related CR Release Date: June 8, 2012

Related Change Request (CR) #: CR 7858
Effective Date:
Effective date for updates to the ESRD PPS consolidated billing requirements: October 1, 2012
Effective date for updates to ESRD-related drugs and biologicals: July 1, 2012

Related CR Transmittal #: R2486CP

Implementation Date: October 1, 2012

Note: *This article was revised on November 30, 2012, to provide the correct CPT code on page 3 for "Assay of Magnesium." All other information remains the same.*

Provider Types Affected

This MLN Matters® Article for Change Request (CR) 7858 is intended for physicians, other providers, and suppliers including End Stage Renal Disease (ESRD) facilities and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers who submit claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), carriers, and/or A/B Medicare Administrative Contractors (A/B MACs)) for ESRD supplies and services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7858 which provides the October 2012 Quarterly Update to the End Stage Renal Disease (ESRD) Prospective Payment System (PPS). See the Background and Additional Information Sections of this article for further details regarding this ESRD PPS update.

Background

The *Medicare Improvements for Patients and Providers Act* (MIPPA; Section 153(b); see **http://www.gpo.gov/fdsys/pkg/PLAW-110publ275/pdf/PLAW-110publ275.pdf**) required the implementation of an End Stage Renal Disease (ESRD) Prospective Payment System (PPS) effective January 1, 2011.

The ESRD PPS provides a single payment to ESRD facilities that covers all of the resources used in furnishing an outpatient dialysis treatment. This includes supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training, and support services. Consolidated billing edits established with the implementation of the ESRD PPS prevent payment to other providers and suppliers billing for renal dialysis services. The ESRD PPS provides payment adjustments for co-morbid conditions identified by specific ICD diagnosis codes. The ICD diagnosis codes are updated annually and effective each year on the first day of October. The ESRD PPS also includes consolidated billing requirements for limited Part B services included in the ESRD facility's bundled payment.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of items and services that are subject to Part B consolidated billing and are therefore no longer separately payable when provided to ESRD beneficiaries by providers other than ESRD facilities. The ESRD PPS also provides outlier payments, if applicable, for high cost patients due to unusual variations in the type or amount of medically necessary care. You can find a list of 1) specific diagnosis codes that are eligible for a co-morbidity payment adjustment, 2) items and services that are subject to the ESRD PPS consolidated billing requirements, and 3) outlier services at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html** on the CMS website.

ICD Diagnosis Coding Updates

There are no new or revised ICD diagnosis codes to implement for the October 1, 2012, ESRD PPS Quarterly Update.

Consolidated Billing Changes

ESRD-Related Drugs and Biologicals

The following new code is being added to the Healthcare Common Procedure Coding System (HCPCS) file for anemia management treatment effective **July 1, 2012**.

Added HCPCS Code	Short Description	Long Description
Q2047	Peginesatide injection	INJECTION, PEGINESATIDE, 0.1 MG (FOR ESRD ON DIALYSIS)

Peginesatide is used as anemia management for ESRD patients on dialysis, therefore the drug is considered to be always ESRD-related. Separate payment for Q2047 (Peginesatide) will not be made with or without the AY modifier.

The claims shall process the line item as covered with no separate payment under the ESRD PPS and under the ESRD PPS portion of the blended payment during the transition **effective October 1, 2012**. However, ESRD facilities that are receiving a blended payment during the transition will receive separate payment under the composite rate portion of the blend effective **July 1, 2012**.

In accordance with 42 CFR 413.237(a)(1), HCPCS code Q2047 (Peginesatide) is considered to be an eligible outlier service, and it will be included in the outlier calculation when CMS provides a fee amount on the Average Sales Price (ASP) pricing file.

ESRD-Related Equipment and Supplies

The following HCPCS code is being added to the list of items and services that are subject to ESRD PPS consolidated billing requirements effective **October 1, 2012**:

Added HCPCS Code	Long Description
A6216	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING

HCPCS code A6216 is ESRD-related, however, this supply can be used for reasons other than for the treatment of ESRD, and it is covered under other Medicare benefit categories. Therefore, A6216 may be billed by DME suppliers with the AY modifier to receive separate payment **effective October 1, 2012**.

Changes to Items and Services that Qualify as an Outlier Service

CMS is removing the following Current Procedural Terminology (CPT) code 83735 (Assay of Magnesium) from the list of outlier services. The "Assay of Magnesium" laboratory test was a composite rate service under the basic case-mix adjusted composite rate system. Consequently, it is considered a renal dialysis service under the ESRD PPS. Therefore, this laboratory test does not qualify as an outlier service under 42 CFR 413.237 **effective October 1, 2012**.

CR7858 also includes the following two attachments:

- Attachment A which contains the following four tables:
  - DME ESRD Supply HCPCS for ESRD PPS Consolidated Billing Edits;
  - DME ESRD Supply HCPCS Not Payable to DME Suppliers
  - Labs Subject to ESRD Consolidated Billing,
  - Drugs Subject to ESRD Consolidated Billing; and
- Attachment B (Outlier Services) which includes one table with three sections:
  - Oral and Other Equivalent Forms of Injectable Drugs,
  - Laboratory Tests, and
  - Syringes.

Note: *The tables in Attachments A & B are updated to include codes A6216 and Q2047, as presented in this article, where applicable.*

Additional Information

The official instruction, CR7858, issued to your DME MACs, FIs, and A/B MACs, regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2486CP.pdf** on the CMS website. If you have any questions, please contact your DME MACs, FIs, or A/B MACs at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Redesign of the Medicare Summary Notice (MSN) - Final Implementation - And Major Update to Chapter 21 of the Claims Process Manual (MM7676) (GEN)

MLN Matters® Number: MM7676
Related CR Release Date: August 21, 2012
Related CR Transmittal #: R2522CP

Related Change Request (CR) #: 7676
Effective Date: January 3, 2013
Implementation Date: January 3, 2013

Provider Types Affected

Physicians, 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 services provided to Medicare beneficiaries.

Provider Action Needed

Impact to You

The content and format of the Medicare Summary Notice (MSN) are redesigned, effective January 3, 2013.

What You Need to Know

In Change Request (CR) 7676, CMS announces that (effective January 3, 2013) the content and format of the MSN have been redesigned. It also announces relevant manual changes that Medicare contractors will use to implement the newly designed document. **Note that MACs will begin phasing the new MSN beginning on January 3, 2013.**

What You Need to Do

You should make sure that your billing staffs are aware of these MSN changes.

Background

Section 1806(a) of the *Social Security Act* (the Act) requires the Centers for Medicare & Medicaid Services (CMS) to provide a Part A, Part B, and/or Durable Medical Equipment (DME) Medicare Summary Notice (MSN) to each Medicare beneficiary. The MSN content and format are impacted by statute, legislation, and court decisions including:

- The *Plain Writing Act of 2010*, which requires all government communications to be written in plain language that is easily understood by the target audience;
- Sections 1806(b), 1816(j), 1842(h)(7), 1848(g), 1869(a)(4), and 1869(a)(4)(C) of the Act;
- 42 C.F.R. Section 405.921;
- Section 925 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (P.L. 108-173); and
- Court decisions Gray Panthers v. Schweiker, 652 F. 2d 146, 168 (D.C. Cir. 1980); David v. Heckler, 591 F.Supp. 1033 (E.D.N.Y 1984); Vorster v. Bowen, 709 F.Supp 934 (C.D. Cal. 1989); and Connecticut Department of Social Services v. Leavitt, 428 F.3d 138 (2d Cir. 2005).

CR7676, from which this article is taken, announces that CMS has undertaken a redesign of the MSN, in order to: 1) make the document current and consistent with all applicable statutes and laws, and 2) to render it more easily and widely understood by the beneficiary population that it serves.

In addition, CR7676 announces that of the "*Medicare Claims Processing Manual*" Chapter 21 (Medicare Summary Notices), Sections 10.3-31 (MSN Redesign) has been updated to reflect the new MSN designs. This update is effective with the final implementation of the new designs on January 3, 2013, and will be used to provide guidance on the implementation of these new MSN designs.

Additional Information

You can find the official instruction, CR7676, issued to your carrier, FI, A/B MAC, RHHI, or DME MAC by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2522CP.pdf** on the CMS website. You will find the updated "*Medicare Claims Processing Manual*" Chapter 21 (Medicare Summary Notices), Sections 10.3-31 (MSN Redesign), and including all of the new (and final) MSN designs as attachments to that CR. If you have any questions, please contact your carrier at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Termination of the Common Working File ELGB Provider Query (MM8086) (GEN)

MLN Matters® Number: MM8086
Related CR Release Date: November 2, 2012
Related CR Transmittal #: R1140OTN
Related Change Request (CR) #: 8086
Effective Date: April 1, 2013
Implementation Date: April 1, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME/MACs), and Part B Medicare Administrative Contractors (B MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8086 which informs Medicare contractors about the changes being made to eliminate the ELGB (eligibility) query. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Medicare providers use the Common Working File (CWF) ELGB query to obtain Medicare beneficiary information. However, the Centers for Medicare and Medicaid Services (CMS) must eliminate this query capability because the ELGB query is not HIPAA compliant because the incoming query and the outgoing response are not in X12 format. CMS is required by HIPAA to use the proper format when exchanging this information with any covered entity, which applies to all users of this query. As a result, CMS is eliminating this query. They can no longer support the approach of allowing providers online access to CWF non-HIPAA compliant data.

While the CWF ELGB query is discontinued, other query capabilities, such as the HIPAA Eligibility Transaction System (HETS), are available. More information on HETS is available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html** on the CMS website. You may also use your Medicare contractor's Integrated Voice Response (IVR) System or their Web portal.

Additional Information

The official instruction, CR8086 issued to your carrier, DME MAC, and B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1140OTN.pdf** on the CMS website. If you have any questions, please contact your carrier, DME MAC, or B MAC at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Updated ICD-10 Implementation Information (SE1239) (GEN)

MLN Matters® Number: SE1239
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Article is intended for all physicians, providers, suppliers, and other covered entities who submit claims to Medicare contractors for services provided to Medicare beneficiaries in any health care setting.

What You Need to Know

This MLN Matters® special edition article replaces article SE1019 and provides updated information about the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM/ICD-10-PCS) code sets to help you better understand (and prepare for) the United States health care industry's change from ICD-9-CM to ICD-10 for medical diagnosis and inpatient hospital procedure coding.

The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at **http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html** on the Centers for Medicare & Medicaid Services (CMS) website.

Thus, on **October 1, 2014**, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by the *Health Insurance Portability and Accountability Act* (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background

ICD-10 Implementation Compliance Date

On October 1, 2014, CMS will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

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

Important, please be aware:

- ***ICD-9-CM codes will not be accepted for services provided on or after October 1, 2014.***
- ***ICD-10 codes will not be accepted for services prior to October 1, 2014.***

  You **must** begin using the ICD-10-CM codes to report diagnoses from all ambulatory and physician services on claims with dates of service on or after October 1, 2014, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2014.

  Additionally, you must begin using the ICD-10-PCS (procedure codes) for all hospital claims for inpatient procedures on claims with dates of discharge that occur on or after October 1, 2014.

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

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

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

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

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

What are Benefits of the ICD-10 Coding System?

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

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

ICD-10-CM Code Use and Structure

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

- A78 - Q fever
- A69.21 - Meningitis due to Lyme disease
- O9A.311 - Physical abuse complicating pregnancy, first trimester
- S52.131A - Displaced fracture of neck of right radius, initial encounter for closed fracture

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

1) Laterality (left, right, bilateral)

For example:

- C50.511 - Malignant neoplasm of lower-outer quadrant of right female breast
- H16.013 - Central corneal ulcer, bilateral
- L89.022 - Pressure ulcer of left elbow, stage II

2) Combination codes for certain conditions and common associated symptoms and manifestations

For example:

- K57.21 - Diverticulitis of large intestine with perforation and abscess with bleeding
- E11.341 - Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- I25.110 - Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

3) Combination codes for poisonings and their associated external cause

For example:

- T42.3x2S - Poisoning by barbiturates, intentional self-harm, sequela

4) Obstetric codes identify trimester instead of episode of care

For example:

- O26.02 - Excessive weight gain in pregnancy, second trimester

5) Character "x" is used as a 5th character placeholder in certain 6 character codes to allow for future expansion and to fill in other empty characters (e.g., character 5 and/or 6) when a code that is less than 6 characters in length requires a 7th character

For example:

- T46.1x5A - Adverse effect of calcium-channel blockers, initial encounter
- T15.02xD - Foreign body in cornea, left eye, subsequent encounter

6) Two types of Excludes notes

Excludes 1 - Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

For example:

- Q03 - Congenital hydrocephalus (Excludes1: Acquired hydrocephalus (G91.-)

Excludes 2 - Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).

- L27.2 - Dermatitis due to ingested food (Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

7) Inclusion of clinical concepts that do not exist in ICD-9-CM (e.g., underdosing, blood type, blood alcohol level)
For example:

- T45.526D - Underdosing of antithrombotic drugs, subsequent encounter
- Z67.40 - Type O blood, Rh positive
- Y90.6 - Blood alcohol level of 120-199 mg/100 ml

8) A number of codes have been significantly expanded (e.g., injuries, diabetes, substance abuse, postoperative complications)
For example:

- E10.610 - Type 1 diabetes mellitus with diabetic neuropathic arthropathy
- F10.182 - Alcohol abuse with alcohol-induced sleep disorder
- T82.02xA - Displacement of heart valve prosthesis, initial encounter

9) Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders
For example:

- D78.01 - Intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
- D78.21 - Postprocedural hemorrhage and hematoma of spleen following a procedure on the spleen

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

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

To learn more about the ICD-10-CM coding structure you may review "Basic Introduction to ICD-10-CM" audio or written transcripts from the March 23, 2010 provider outreach conference call, which is available at **http://www.cms.gov/Medicare/Coding/ICD10/index.html** on the CMS website.

ICD-10-PCS Code Use and Structure

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

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

Help with Converting Codes

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

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

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

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

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

Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings" (**http://www.cms.gov/Medicare/Coding/ICD10/index.html** on the CMS website).

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

If you have not already done so, here are the steps you need to consider to implement ICD-10:

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

Additional Information

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

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

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

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

- **See MLN Matters® Special Edition Article, SE1240**, at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1240.pdf** for a discussion of a partial freeze on ICD-10 code set prior to implementation.

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

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

Fee Schedule Updates (GEN)

The 2012 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:

The following Fee Schedules have been added:

- There are no updates to the 4th Quarter 2012 Jurisdiction A DME MAC Fee Schedule
- 4th Quarter 2012 Average Sales Price Medicare Part B Drug Pricing File
- 4th Quarter 2012 Oral Anticancer Drug Fees

The following Fee Schedules have been revised:

- 3rd Quarter 2012 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2012 Average Sales Price Medicare Part B Drug Pricing File

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.

CMS e-News Links (GEN)

September

CMS e-News for Wednesday, September 12, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-12-e-News.pdf

CMS e-News for Wednesday, September 19, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-19-e-News.pdf

CMS e-News for Wednesday, September 26, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-26-e-News.pdf

October

CMS e-News for Thursday, October 4, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-04-e-News.pdf

CMS e-News for Thursday, October 11, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-11-e-News.pdf

CMS e-News for Thursday, October 18, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-18-e-News.pdf

CMS e-News for Thursday, October 25, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-10-25-e-News.pdf

November

CMS e-News for Thursday, November 1, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-01-e-News.pdf

CMS e-News for Thursday, November 8, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-08-Enews.pdf

CMS e-News for Thursday, November 15, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-15-e-News.pdf

CMS e-News for Wednesday, November 21, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-21-e-News.pdf

CMS e-News for Thursday, November 29, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-11-29-e-News.pdf

December

CMS e-News for Thursday, December 06, 2012
http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-12-06-e-News.pdf

CMS News Flash (GEN)

The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012. This final rule is available at **http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html** on the Centers for Medicare & Medicaid Services (CMS) website. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice. Keep Up to Date on ICD-10. Please visit the ICD-10 website (**http://www.cms.gov/Medicare/Coding/ICD10/index.html**) for the latest news and resources to help you prepare.

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

The Centers for Medicare & Medicaid Services has posted an updated Medicare FFS Version 5010 835 Health Care Claim Payment/Advice Companion Guide
(**https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Downloads/5010A1835CG.pdf**) to the Medicare FFS Companion Guides (**https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html**) web page.

On November 17, 2011, the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement with respect to any *Health Insurance Portability and Accountability Act* (HIPAA) covered entity that is not in compliance on January 1, 2012, with the ASC X12 Version 5010 (Version 5010), National Council for Prescription Drug Programs (NCPDP) Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards until March 31, 2012. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains January 1, 2012. (Small health plans have until January 1, 2013, to comply with NCPDP 3.0.)

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/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf** for a complete list of all MLN products related to Medicare provider-supplier enrollment.

In response to shortage of liposomal doxorubicin (Doxil), the Food and Drug Administration is permitting the temporary importation of Lipodox, a brand of liposomal doxorubicin hydrochloride. Visit **http://www.FDA.gov/NewsEvents/Newsroom/PressAnnouncements/ucm292658.htm** for additional information. The Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Quarterly Update includes two new codes (Q2048 and Q2049) for liposomal doxorubicin that will become effective Sunday, July 1, 2012. The code descriptors are worded in a manner that distinguishes Lipodox and Doxil. As of Sunday, July 1, 2012, HCPCS code J9001 will not be used for Medicare billing. CMS will release a Change Request (CR) with additional instructions in the near future.

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/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html** on the Centers for Medicare & Medicaid Services (CMS) website.

On August 24, Health and Human Services (HHS) Secretary Kathleen Sebelius announced a final rule that will save time and money for physicians and other health care providers by establishing a unique Health Plan Identifier (HPID). The rule is one of a series of changes required by the *Affordable Care Act* to cut red tape in the health care system and will save up to $6 billion over ten years. Currently, when a health care provider bills a health plan, that plan may use a wide range of different identifiers that do not have a standard format. As a result, health care providers run into a number of time-consuming problems, such as misrouting of transactions, rejection of transactions due to insurance identification errors, and difficulty determining patient eligibility. The change announced on August 24 will greatly simplify these processes. For more information, see the Fact Sheet (**http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4443**) related to this final rule.

The Medicare Learning Network® (MLN) Product Ordering System was recently upgraded to add new enhancements. You can now view an image of the product and access its downloadable version, if available, before placing your order. To access a new or revised product available for order in hard copy format, go to MLN Products (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html**) and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the web page.

NEW products from the Medicare Learning Network® (MLN)

- "*Screening Pelvic Examinations*," Booklet, ICN 907792, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-Pelvic-Examinations.pdf**

- "*Providing the Annual Wellness Visit (AWV)*," Booklet, ICN 907786, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AnnualWellnessVisit-ICN907786.pdf**

- "*Cardiovascular Disease Services*," Booklet, ICN 907784, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Cardiovascular-Disease-Services-Booklet-ICN907784.pdf**

- "*Screening Pap Tests*," Booklet, ICN 907791, Downloadable only. **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-Pap-Tests-Booklet-ICN907791.pdf**

REVISED products from the Medicare Learning Network® (MLN)

- "*Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities*," Educational Tool, ICN 906983, Downloadable only.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ContractorEntityGuide_ICN906983.pdf

- "*The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations*," Fact Sheet, ICN 903767, Downloadable only
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243426.html

- "*Basic Medicare Information for Providers and Suppliers*," Guide, ICN 005933, Downloadable only.
  http://www1d.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Basic-Medicare-Information-for-Providers-and-Suppliers-Guide-ICN005933.pdf

- "*Preventive Immunizations*," Booklet, ICN 907787, Downloadable only.
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Preventive-Immunizations-ICN907787.pdf

Hurricane Sandy - Highlights & Headlines

NHIC has developed a Highlights and Headlines section of our Web site devoted specifically to Hurricane Sandy. Many resources and documents can be located in this section, providing guidance on the submission of claims and related regulations for this disaster recovery situation. Please be sure to review this section of our Web site periodically:

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

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

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Centers for Medicare & Medicaid Services Approved Clinical Trials (GEN)

The Centers for Medicare & Medicaid Services (CMS), in the development of National Coverage Determinations (NCDs), created a category of "Coverage with Evidence Development." Coverage with Evidence Development (CED) provides limited Medicare coverage for beneficiaries enrolled in CMS-approved clinical trials and requires the collection of additional patient data to supplement standard claims data.

Currently CMS has published three (3) NCDs under DME MAC jurisdiction that provide for coverage under CED:

1. Transcutaneous Electrical Nerve Stimulation (*NCD Manual*, Chapter 1, Section 160.27);
2. Home Use of Oxygen in Approved Clinical Trials (*NCD Manual*, Chapter 4, Section 240.2.1)
3. Home Oxygen Use to Treat Cluster Headaches (*NCD Manual*, Chapter 4, Section 240.2.2)

Information regarding which clinical trials are approved by CMS under CED may be found on the CMS Web site at: **http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html**. Suppliers should utilize this resource in order to verify the participation of the beneficiary in a CMS-approved clinical trial and to determine the proper **ClinicalTrials.Gov** study identifier. As of October 5, 2012, no clinical studies involving TENS for treatment of chronic low back pain (CLBP) or home use of oxygen for cluster headaches have been approved by CMS. There is one CMS-approved study for the home use of oxygen in approved clinical trials - Long-Term Oxygen Treatment Trial (**ClinicalTrials.Gov** Identifier NCT00692198).

Coverage of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items for beneficiaries enrolled in CMS-approved clinical trials must meet specific documentation requirements, including providing the specific **ClinicalTrials.Gov** identifier. Suppliers are strongly encouraged to review the Local Coverage Determinations (LCDs) and policy articles (PAs) located on the NHIC, Corp. DME MAC A Web Site to review the guidelines for billing and coverage when the DMEPOS item is being used for a beneficiary due to inclusion in a clinical trial. If LCDs and PAs are not available for the DMEPOS item being billed, a National Coverage Determination may be available. Suppliers can access NCDs in the Internet-Only Manual Publication 100-03, *Medicare National Coverage Determinations Manual* on the CMS web site at
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

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Changing a 7-Element-Order for a Power Mobility Device (MOB)

The DME MACs continue to receive questions about making a change to a 7-Element-Order for a Power Mobility Device. To minimize possible misunderstanding, it is recommended that when the need for a correction is identified, the supplier should request that the physician who completed the original 7-Element-Order complete and submit a *new* 7-Element-Order.

If a new 7-Element-Order cannot be obtained, a *corrected* 7-Element-Order is acceptable only when properly corrected/amended by the physician who originally signed it. A properly corrected/amended record must:

1. Clearly and permanently identify any alteration or addition
2. Clearly indicate the date and author of any alteration or addition
3. Preserve the legibility of the original order by means of a single, narrow line made through any deletion.

Any deletion made and/or any addition written must be completed only by the physician who created the original 7-element-Order, who must legibly sign and date each change as noted above.

In addition, a corrected 7-Element-Order is acceptable only when the corrections/amendments are made *prior* to the completion of any Detailed Product Description (DPD). Furthermore, the correction/amendment must be completed prior to the Date of Service (DOS) of the claim.

Consumable Supplies - Request for Refill Documentation Requirements (GEN)

The Durable Medical Equipment Medicare Administrative Contractors have been conducting reviews on claims for consumable supplies. One of the top reasons for denials has been request for refill documentation. The most common errors involve how suppliers are documenting the quantity of an item the beneficiary has remaining.

For consumable supplies, i.e. those that are used up (e.g., ostomy, urological supplies, surgical dressings, or glucose supplies etc.) the supplier must sufficiently assess the quantity of each item that the beneficiary still has on hand, to determine that the amount remaining will be nearly exhausted. The following are some examples (not all-inclusive) of documentation that is not sufficient to justify reimbursement:

- "Yes" or "No" questions only regarding whether the beneficiary wants or needs more supplies.
- Documentation which only provides information regarding the amount of supplies the beneficiary is requesting.
- Documentation which only states that the beneficiary has less than the required threshold number of supplies left, e.g., Mrs. J stated that she has less than 14 days of glucose strips left.

Vague or nonspecific references to the quantity remaining are not sufficient to demonstrate compliance with the requirement that refills be provided when the current supply on hand is "approaching exhaustion". There must be an individualized and detailed record that quantifies the beneficiary's remaining supplies. An actual count is recommended but not necessary, but the record should evidence that an individual assessment has been performed. Note that a quantitative or semi-quantitative assessment actually performed individually for each refill would not have identical language in the record for each subsequent refill for the same beneficiary. Likewise, identical language for different beneficiaries would raise suspicions about whether individual assessments were actually performed.

There must be sufficient, specific and credible information regarding the quantity the beneficiary still has remaining for the reviewer to be able to determine that the quantity was actually assessed and will be approaching exhaustion on the delivery date, as required by CMS, *Program Integrity Manual*, Chapter 5, section 5.2.6.

For more information regarding these items and their requirements, refer to the local coverage determination and policy articles, *Supplier Manual*, and the standard documentation language articles.

Coverage Reminder - Testing for Oxygen and Oxygen Equipment Coverage (OXY)

Coverage for oxygen and oxygen equipment is dependent upon the presence of conditions that cause chronic hypoxemia. When the underlying condition is in the chronic stable state, blood oxygen testing may be performed by a qualified provider of laboratory services to evaluate the degree of hypoxemia. This result is used to assess eligibility for Medicare reimbursement for oxygen and oxygen equipment. This article serves to summarize essential information regarding oxygen testing.

There are two types of tests that may be used to assess the beneficiary. Acceptable tests are:

- Arterial Blood Gas (ABG) testing - direct testing of oxygen content from an arterial blood sample

- Oximetry - also known as "spot" or "pulse" oximetry involves the determination of percent (%) oxygen saturation via a transcutaneous sensor. There are three types of oximetry testing used for qualification for payment:
    - At rest oximetry
    - Overnight oximetry
    - Exercise oximetry

For purposes of oxygen reimbursement, all testing must be performed as a stand-alone test and not as a part of a more extensive or complex test such as home sleep testing for obstructive sleep apnea or cardiac stress testing. A single exception exists for titration polysomnography. Refer to BOTH the Positive Airway Pressure Devices and Oxygen and Oxygen Equipment policies for additional information about this testing scenario.

For purposes of oxygen reimbursement, all testing must be performed by a qualified provider of laboratory services and be directly supervised by medical personnel qualified to perform the test. A single exception exists for home overnight oximetry. Refer to the Oxygen and Oxygen Equipment policy for additional information about this testing scenario.

Exercise oximetry requires that three (3) oximetry values be obtained during the same testing session. The three requires tests are:

- At rest oximetry on room air showing a non-qualifying result
- Oximetry while exercising on room air showing a qualifying result
- Oximetry while exercising on oxygen showing an improvement in the hypoxemia identified while exercising on room air

Oximetry obtained after exercise while resting, sometimes referred to as "recovery" testing, is not part of the three required test elements for exercise testing and is not valid for determining eligibility for oxygen coverage. For billing purposes, the test result obtained while exercising on room air should be reported on the Certificate of Medical Necessity (CMN).

Testing for oxygen qualification is associated with two additional requirements, which must be met in order for the testing to be acceptable for reimbursement. These requirements are:

- Timing of the test
    - For all oxygen groups (i.e., Group I, II and III), initial testing must be done within the 30 days before the initial date of service
    - For Group II beneficiaries, recertification testing must be done between day 61 - 90 after the initial date of service
- Treating physician visit
    - For all oxygen groups (i.e., Group I, II and III), for the initial testing, a physician visit must be done within the 30 days before the initial date of service
    - For all recertification's, a physician visit must be done within 90 days before the recertification date

Refer to the Oxygen and Oxygen Equipment LCD and related Policy Article for additional information.

Coverage Reminder - Transcutaneous Electrical Nerve Stimulators (TENS) Used For Chronic Low Back Pain (SPE)

Effective for dates of service on or after June 08, 2012 TENS and related supplies used for chronic low back pain (CLBP) are only covered when the beneficiary is a participant in a CMS-approved clinical trial and has one or more required diagnoses. All other claims for TENS and related supplies used for CLBP will be denied as not reasonable and necessary. Only the following diagnoses (ICD-9) will justify coverage:

- 353.4 Lumbosacral root lesions, not elsewhere classified
- 720.2 Sacroiliitis, not elsewhere classified
- 721.3 Lumbosacral spondylosis without myelopathy
- 721.42 Thoracic or lumbar spondylosis with myelopathy - lumbar region
- 722.10 Lumbar intervertebral disc without myelopathy
- 722.52 Lumbosacral intervertebral disc
- 722.73 Intervertebral disc disorder myelopathy - lumbar region

- 722.83 Post laminectomy syndrome - lumbar region
- 722.93 Other and unspecified disc disorders, lumbar region
- 724.02 Spinal stenosis, lumbar region without neurogenic claudication
- 724.03 Spinal stenosis, lumbar region with neurogenic claudication
- 724.2 Lumbago
- 724.3 Sciatica
- 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified, radicular syndrome of lower extremities
- 738.4 Acquired spondylolysthesis
- 739.3 Non-allopathetic lesions NEC (not elsewhere classified) - lumbar region
- 756.11 Spondylosysis, lumbosacral region
- 756.12 Spondylolisthesis
- 805.4 Fracture of vertebral column without mention of spinal cord injury, lumbar, closed
- 806.4 Fracture of vertebral column with mention of spinal cord injury, lumbar, closed
- 846.0 Sprains and strains of sacroiliac region - lumbosacral (joint) (ligament)
- 846.1 Sprains and strains of sacroiliac ligament
- 847.2 Sprains and strains of other and unspecified parts of back, lumbar
- 953.2 Injury to nerve roots and spinal plexus, lumbar root

The beneficiary must be enrolled in an approved clinical study that meets all of the requirements set out in NCD §160.27 (CMS Internet Only Manual 100-3, Chapter 1). Refer to the DOCUMENTATION REQUIREMENTS and APPENDICES sections of TENS LCD for additional information about approved clinical studies.

Coverage requirements for TENS and related supplies used for non-CLBP remain unchanged. Refer to the INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY section of LCD for additional information about coverage for non-CLBP conditions.

Information concerning documentation required for TENS used for CLBP may be found in the LCD. Also Refer to the *Supplier Manual* for additional information about general documentation requirements.

LCD and Policy Article Revisions Summary for December 06, 2012 (GEN)

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

Ankle-Foot/Knee-Ankle-Foot Orthoses

Policy Article

Revision Effective Date: 01/01/2013

CODING GUIDELINES:

Revised: Height definition for AFO codes L1900, L1910-L1990

Spinal Orthoses: TLSO and LSO

LCD

Revision Effective Date: 01/01/2013

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Order requirements language to specify a “detailed written order”

HCPCS CODES AND MODIFIERS:

Added: L0621 & L4002

DOCUMENTATION REQUIREMENTS: (Note: The effective date above is not applicable to this section. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference)

Added: Prescription (Order) requirements, detailed written order requirements, proof of delivery requirements, general medical record requirements and repair/replacement requirements

APPENDICES:
Added: PIM citation

Spinal Orthoses: TLSO and LSO

Policy Article

Revision Effective Date: 01/01/2013
CODING GUIDELINES:
Added: Definition of rigid and semi-rigid orthotic
Added: Clarification on spinal orthotic functionality
Added: L0621

Note: *The information contained in this article is only a summary of revisions to the LCD 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 November 9, 2012 (GEN)

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

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 01/01/2013 (Cluster headache related items are effective 10/01/2012)
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Long Term Oxygen Therapy Trial by creating stand-alone section and adding reference to APPENDICES section
Revised: Cluster Headache section to include change to codes E0424 and E0441 and clinical study ID number information (Effective 10/01/2012)
Added: Definitions for qualifying testing types to minimize confusion with other respiratory testing done for other purposes
Revised: Renamed home sleep testing to be referred to as "overnight oximetry" to minimize confusion with home sleep testing done to diagnose obstructive sleep apnea
Added: Clarification about supervision for testing
Added: Information about when the use of polysomnogram oximetry results is acceptable to justify the reimbursement of oxygen
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: V70.7 as concurrent diagnosis requirement (Effective 10/01/2012)
DOCUMENTATION REQUIREMENTS:
Added: Long Term Oxygen Therapy Trial section
Added: "Clinicaltrials.gov" ID number requirement for long term oxygen therapy trials
Added: Q0 (zero) modifier requirement to long term oxygen therapy trials
Added: V70.7 instructions for cluster headache (Effective 10/01/2012)
Added: "Clinicaltrials.gov" ID number requirement for cluster headache (effective 10/01/2012)
APPENDICES:
Added: Clinical trials information

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

LCD

Revision Effective Date: 01/01/2013
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirement language to specify a "detailed written order"
Added: Concurrent use of oxygen and PAP coverage requirements
DOCUMENTATION REQUIREMENTS:

Added: Concurrent Use of Oxygen with PAP Therapy

(**Note:** *The effective date above is not applicable to the documentation revisions described below. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

Revised: Prescription requirements

Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

Suction Pumps

Policy Article

Revision Effective Date: 04/15/2012

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Bundling requirement for A4605 as included in payment for ventilator and supplies (applies to all ventilator codes in the Frequent and Substantial Servicing pricing category)

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

LCD and Policy Article Revisions Summary for November 2, 2012 (GEN)

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

Manual Wheelchair Bases

LCD

Revision Effective Date: 03/01/2013

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Coverage criteria for K0005 to conform with DMEPOS Quality Standards reclassification as a rehabilitation product

Policy Article

Revision Effective Date: 05/01/2012 (November 2012 publication date)

CODING GUIDELINES:

Deleted: Wheel size requirement of E1161

Suction Pumps

LCD

Revision Effective Date: 04/15/2012 (November 2012 publication)

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Coverage for A4605 to link it as a supply to E0600

Revised: Moved required diagnosis codes for A4605 and A4624 from DOCUMENTATION REQUIREMENTS section to coverage section

Added: Additional ICD-9 diagnosis codes describing tracheostomy status (519.00, 519.01, 519.02, 519.09)

Revised: Wound suction pump explanation about rationale for noncoverage to improve readability

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: 519.00, 519.01, 519.02, 519.08 - ICD-9 Codes for A4605 and A4624

DOCUMENTATION REQUIREMENTS:

Revised: ICD-9 requirements for A4605 and A4624 (moved to INDICATIONS AND LIMITATIONS OF MEDICAL NECESSITY section)

Revised: Updated REFILL REQUIREMENTS to include expanded description of consumable and durable supplies as separate bullets

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

LCD and Policy Article Revisions Summary for October 2012 (GEN)

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

Transcutaneous Electrical Nerve Stimulators (TENS)

LCD

Revision Effective Date: 06/08/2012

INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:

- Revised: Reformatted coverage criteria to separate the different coverage conditions
- Revised: "Chronic pain" to separate CLBP from other types of chronic pain
- Added: Coverage for CLBP to add diagnosis and approved study requirements (CR 7836)

HCPCS CODES AND MODIFIERS:

- Added: Q0 (zero) modifier

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY

- Added: Diagnosis for CLBP coverage

DOCUMENTATION REQUIREMENTS:

- Revised: CMN requirements to exclude CLBP
- Added: Guidance for documenting coverage

(**Note:** *The effective date above is not applicable to the documentation revisions described below. These revised and added requirements are existing Medicare requirements which are now included in the LCD for easy reference*)

- Revised: Prescription requirements
- Added: Refill requirements, general medical record information requirements, continued use and continued need requirements, and proof of delivery requirements

APPENDICES:

- Added: Reference for PIM citations
- Added: Information about "Coverage with Evidence Development" and "Clinicaltrials.gov" study identification number

Wheelchair Options/Accessories

Policy Article

Revision Effective Dated: 11/01/2012

CODING GUIDELINES:

- Added: E1020/E1028 clarification and addition to bundling table

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

Medicare Eligibility and Documentation Requirements for DMEPOS items Obtained Prior to Medicare Eligibility (GEN)

Once a beneficiary becomes Medicare eligible and is seeking payment for a DMEPOS item(s) obtained prior to their eligibility, all Medicare Fee-for-Service (FFS) payment and documentation rules are applicable to the DMEPOS item(s) on the date of service for the item(s).

Purchased items (including supplies)

If, at the time of transition to Medicare, the beneficiary owns a DMEPOS item that can be purchased under the Medicare program, Medicare can pay for reasonable and necessary supplies and repairs to that item. At the time of replacement of that entire item, Medicare treats the claim as a new, initial claim (not as a replacement). Therefore, all coverage and documentation requirements must be met to justify reimbursement for the item. Refer to the applicable local coverage determination and related policy article for specific information about coverage, coding and documentation. For durable medical equipment, only certain items can be paid for on a purchase basis under the Medicare program. Medicare payment can only be made for necessary supplies and repairs of beneficiary-owned equipment that Medicare can purchase, which includes items classified under the Medicare program as inexpensive or routinely purchased items, complex rehabilitative power wheelchairs, or customized items uniquely constructed or substantially modified for a specific patient. This applies in all situations, including situations where the equipment is purchased prior to Medicare eligibility.

Rental items

For rental items, i.e. the beneficiary does not own the item at the time of transition to Medicare: Medicare does not automatically assume payment for the item. Rental coverage by Medicare is treated as a new, initial claim (not as a replacement). Therefore, all coverage and documentation requirements must be met to justify reimbursement for the item. Refer to the applicable local coverage determination and related policy article for specific information about coverage, coding and documentation.

The disposition of the original item rests with the original payer, not Medicare. In addition to meeting Medicare's coverage requirements, Medicare requires that the Medicare-billed equipment be new or refurbished at the start of an initial rental.

All rented equipment must remain in good working order for the entire 5 year reasonable useful lifetime of the equipment. If the equipment does not last for the entire 5 year reasonable useful lifetime, the supplier must replace the equipment at no charge to Medicare or the beneficiary (42 CFR 414.210(e) (4)). When billing for the Medicare initial date of service, standard documentation requirements, including proof of delivery, apply (PIM 4.26, 5.8).

Results from recent reviews have uncovered several misconceptions about the documentation requirements for claims for a beneficiary who previously received equipment from a prior insurer. Some of these mistakes include:

1. Changes to the proof of delivery (POD) are not annotated. This is incorrect. Any changes or corrections on the POD must show that the beneficiary or caregiver has signed or initialed, and dated the changed document.
2. The proof of delivery provided is from the delivery with the previous payer which is not appropriate to demonstrate proof of delivery for a new Medicare item. For items that require a CMN, the "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DME Information Form (DIF) or the start date on the written order.

Suppliers must follow the standard documentation language regarding the elements required for proof of delivery based on the method of delivery. For more information refer to the *Supplier Manual*.

TMP-EDO-0058 Ver. 4 09/18/2012

Numerical Rounding Rules for Medicare (OXY)

Recently several questions have arisen about how to handle reporting test results and determining coverage when the values are not whole numbers. This most often occurs for oxygen saturation results (either arterial blood gas or pulse oximetry) and sleep tests where the apnea/hypopnea index (AHI) or respiratory disturbance index (RDI) results are expressed with a decimal place.

In both of these instances, standard numerical rounding rules apply. For example, consider a sleep test where the AHI is reported as below:

If the value is 12.01 to 12.49, round down to 12
If the value is 12.50 to 12.99, round up to 13.

The only exceptions to this rule are where Medicare policy makes clear that the specified level is absolute and rounding is not to be used. One such situation is in the completion of Question 5 on the Oxygen Certificate of Medical Necessity ("Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an 'X'."). No rounding is allowed for flow rates less than 1.0.

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

Historical Review Results

DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed January 2012 thru April 2012 and resulted in a 68.7% Charge Denial Rate (CDR).

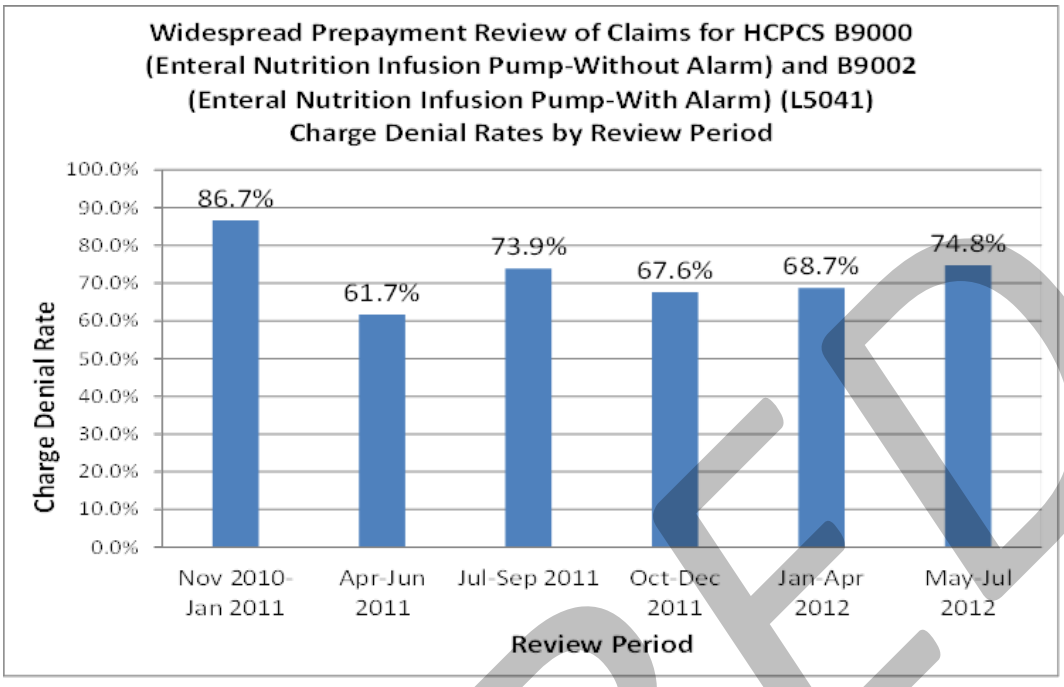
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm). These findings include claims processed primarily from May 1, 2012 through July 31, 2012.

The review involved prepayment complex medical review of 1368 claims submitted by 187 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 303 (22%) of the claims. For the remaining 1043 claims, 260 claims were allowed and 783 were denied/partially denied resulting in a claim denial rate of 75%. 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 74.8 %.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

Based on 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:

Clinical Documentation Issues

- 16% of the denied claims had insufficient clinical documentation to justify the LCD criteria.
  - (a) a permanent non-function or disease of the structures that normally permit food to reach the small bowel (b) a disease of the small bowel which impairs digestion and absorption of an oral diet.
  - **Note:** *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- 31% of the denied claims did not have any medical record documentation submitted.

Proof of Delivery

- 25 % of the denied claims had no Proof of Delivery

Detailed Written Order Issues

- 21% of the denied claims had missing detailed written orders.
- 19% of the denied claims had an incomplete detailed written orders.
  - Date of the detailed order was incomplete (missing month or year)
  - Physician's signature could not be authenticated

DME MAC Informational Form (DIF) Discrepancies

- 10% of the denied claims were missing a DIF.

Claim Examples

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

Example 1:

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

Example 2:

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

Example 3:

Received: DIF and Delivery ticket
Missing: From MD detailed written order, clinical records to support coverage for Enteral nutrition and /or the Enteral infusion pump per LCD 5041 requirements.

Next Step

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

Educational References

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

- Enteral Nutrition (L5041) LCD and related Policy Article (A25229)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

- Results of Widespread Prepayment Probe for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (issued 03/11/2011)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/031111_B9000.pdf

- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (issued 07/20/2012, 05/11/2012, 12/22/2012, 09/20/2011, and 03/11/2011)
  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 - Enteral Nutrition
  http://www.medicarenhic.com/dme/CERT/EN_phy_letter_doc.pdf

- Enteral Nutrition Units of Service Calculator
  http://www.medicarenhic.com/dme/self-service.shtml

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

- Enteral Nutrition Supply Kits - Coverage Reminder
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_enteral-kits.pdf

Results of Widespread Prepayment Review for 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 March 2012 through May 31, 2012 and resulted in a Charge Denial Rate (CDR) of 68.7%.

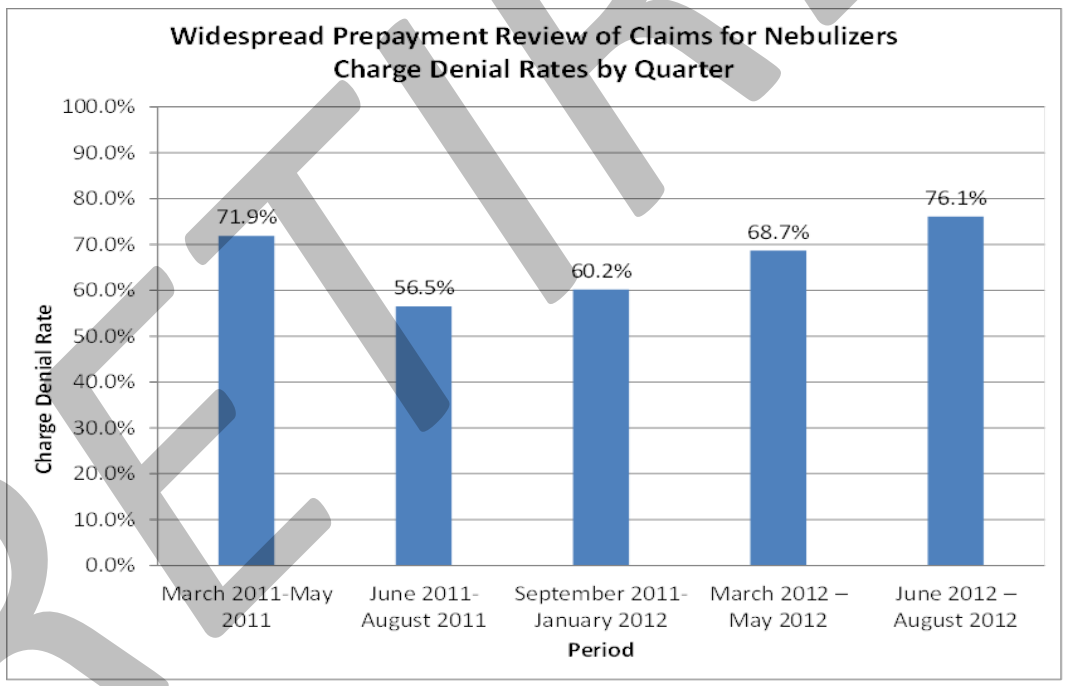
Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings include claims processed primarily from June 2012 through August 31, 2012. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

The review involved prepayment complex medical review of 1228 claims submitted by 503 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 181 (15%) of the claims. For the remaining 1042 claims, 232 claims were allowed and 810 were denied/partially denied resulting in a claim denial rate of 78%. 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 76.1%.

Charge Denial Rate Historical Data

The following data 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. Note that the percentages detailed below reflect the fact that a claim could have more than one missing/incomplete item:

Clinical Documentation Issues

- 55.4% of the denied claims were missing any clinical information to support medical necessity. No medical records of any sort were submitted.

- 29% of the denied claims had insufficient clinical documentation. The documentation submitted had no relevance to nebulizer use.

Detailed Written Order Issues

- 11.6% of the denied claims were missing the detailed written order.

Proof of Delivery Issues

- 17.6% of the denied claims were missing proof of delivery.

Claim Examples

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

Example 1:

Received: Detailed physician's order with legible signature and date of signature, delivery ticket including recipients/caregiver signature and date of receipt and payable diagnosis.
Missing: Clinical notes do not explain reasonable and necessary use of nebulizer.

Example 2:

Received: Claim received with clinical notes from MD, completed delivery ticket including payable diagnosis.
Missing: Written detailed order with beneficiary name, description of item to be dispensed, ordering physician's legible signature, and date of physician signature.

Example 3:

Received: Detailed order with beneficiary name, physician's legible signature and date of signature, clinical records and payable diagnosis.
Missing: As proof of delivery missing: no receipt signature, no receipt date or delivery ticket at all.

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, March 25, 2011, July 01, 2011, December 22, 2011, April 20, 2012, and August 17, 2012
  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 (April 2011, May 2011, July 2011, January 2012, February 2012, and May 2012, August 2012)
  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 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 the previous review findings. The previous quarterly findings covered claims reviewed from January 2012 through March 2012 and resulted in a 38.8% Charge Denial Rate (CDR).

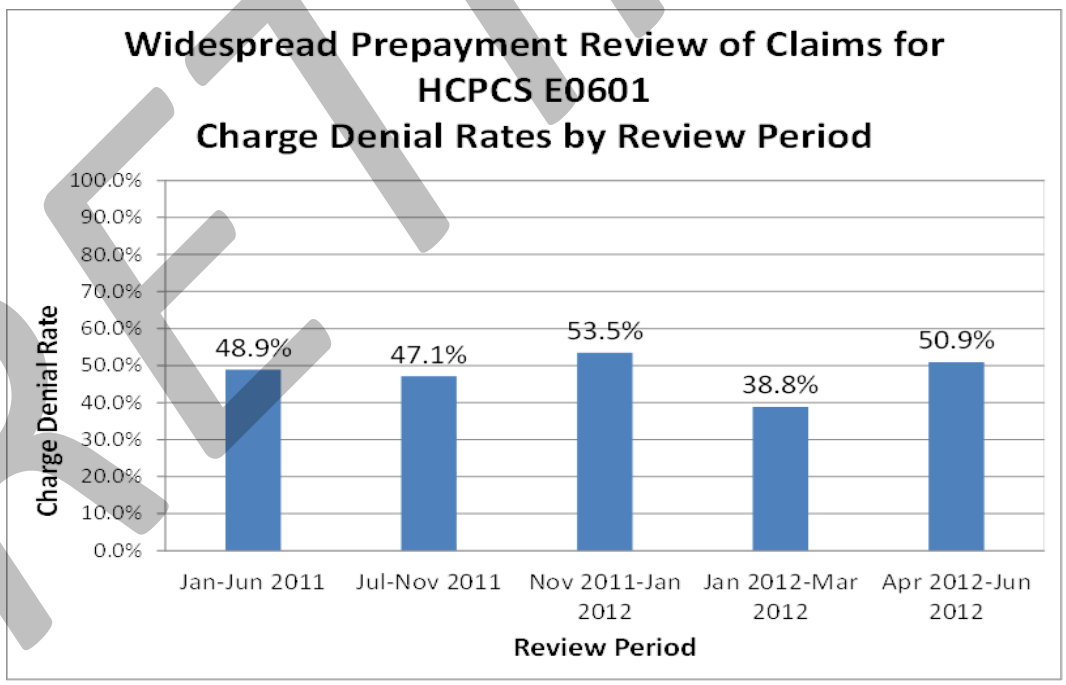
Current Review Results

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 processed from April 2012 through June 2012. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 855 claims submitted by 295 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 244 (28%) of the claims. Of the 611 claims for which responses were received, 279 claims were allowed and 332 were denied/partially denied. This resulted in a claim denial rate of 54%. 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 50.9%.

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

- 48.0% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination.
    - These claims had no Face to Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face to Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare.
- 12.0% 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. The insufficient clinical documentation included:
    - Clinical documentation provided 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 noted in Face to Face evaluations conducted by the treating physician in 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.
- 7.1% of the denied claims were missing the MD signature on the Face to Face clinical evaluation.
- Less than 1% of the denied claims had illegible Face to Face documents.

Detailed Written Order Issues

- 2.6% of the denied claims did not include the Detailed Written Order.
- 1.1% of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- 1.1% of the denied claims had Detailed Written Orders that were illegible.
- 0.4% of the denied claims had Detailed Written Orders that were not dated by the treating physician.

Sleep Study Documentation Issues

- 6.7% of the denied claims did not include a copy of the original Medicare Covered Sleep Study.
- 0.7% of the denied claims had sleep study documents that did not meet coverage criteria per the PAP LCD.
- 15.0% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.

Training Documentation Issues

- 15.0% of the denied claims did not include evidence of training on the PAP device.
- 1.5% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face to face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 3.0% of the denied claims were missing Proof of Delivery.
- 8.2% of the denied claims were missing billed items on the Proof of Delivery.
- 3.4% of the denied claims were delivered after the Date of Service.

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: Included in this claim was a Detailed Written Order, evidence of training on the PAP device, and a Medicare approved Sleep Study.

Missing: This claim is missing a Face to Face clinical evaluation by the treating practitioner prior to the Sleep Study that addresses 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. This claim is also missing Proof of Delivery that the beneficiary received the items prescribed by the physician.

Example 2:

Received: Included in this claim was a Face to Face clinical evaluation, a Detailed Written Order, evidence of training on the PAP device, a Medicare approved Sleep Study.
Missing: The Proof of Delivery submitted with this claim is missing items listed on the ADS letter.

Example 3:

Received: Included in this claim are a Face to Face clinical evaluation, a Detailed Written Order, a copy of the original Home Sleep Study, evidence of training on the PAP device, and Proof of Delivery.
Missing: Medicare requires that services provided be authenticated by the treating practitioner. There was no real or electronic signature or attestation statement found on the Face to Face clinical evaluation by the treating practitioner. This claim is also missing the required training prior to taking a Home Sleep Study demonstrating that they received verbal/phone/video instruction on how to properly apply a portable sleep monitoring device.

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.

NHIC appreciates the hard work by suppliers that has resulted in improvements in the error rate over the past year. We encourage all suppliers to continue to examine E0601 claims for compliance with all of the LCD requirements.

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 8/24/12, 04/20/2012, 12/22/2011, 08/19/2011, 3/4/2011 and 07/02/2010
  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 general 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

- CERT Errors (Monthly Publications)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

- Frequently Asked Questions (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faq_results.asp?categories=DME

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) (MOD)

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, 2012 through April 30, 2012, and resulted in a 54.7% percent Charge Denial Rate (CDR).

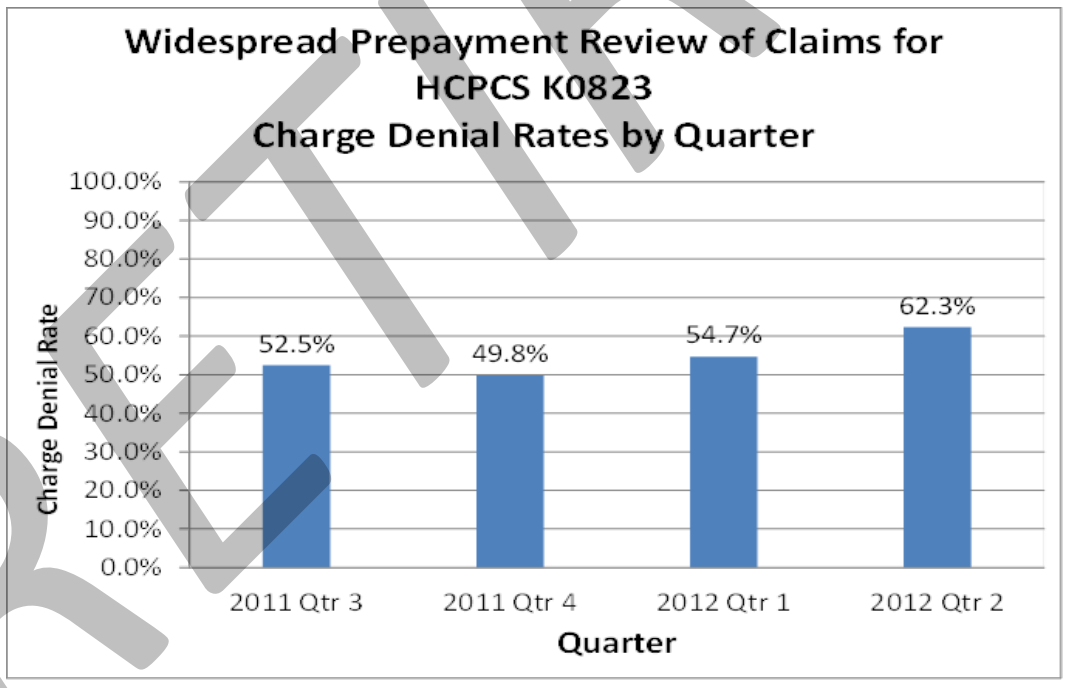
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS code K0823). These findings include claims with dates processed from April 2012 through June 2012. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 514 claims submitted by 188 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 25 (5%) of the ADR requests issued. Of the claims for which responses were received, 128 (26%) of the claims were allowed and 361 (74%) of the claims were denied. This resulted in a claim denial rate of 73.8%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 62.3%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Insufficient Documentation (56%)

- 22% - Reasonable and Necessary issues include the following:
    - Documentation available from the mobility exam is insufficient as it does not include a comprehensive face to face exam by the treating physician that objectively addresses mobility limitations and provide a clear picture of the patient's mobility deficits. Sufficient objective measurements were not provided.
    - Face to Face record is a supplier generated form which the treating physician completed. No comprehensive narrative clinical documentation was received which reflects a clear understanding of the beneficiary's mobility with measured recordings of patient's upper and lower extremity strength and range of motion.
- 34% - *Incomplete or missing documentation includes the following:*
- 3% - Face to Face exam was not included.
- 19% - 7 Element F2F date did not match Face to Face performed by treating physician or in concurrence/disagreement of specialty exam.
- 12% (total) for the following:
    - Illegible documentation.
    - Face to Face exam received, however, the document was incomplete due to either Face to Face exam not dated or signed by treating physician.
    - No treating physician signature in concurrence or disagreement with specialty exam.

7 Element Order Issues (30%)

- 16% - Incomplete 7 Element orders; missing one or more required elements.
- 2% - No 7 Element order.
- 6% - 7 Element orders which did not include confirmation the supplier received a copy within 45 days after the completion of the Face to Face exam; as verified by a supplier date stamp or equivalent.
- 6% (total) - for the following :
    - Illegible 7 Element order.
    - 7 Element order and detail product description were on the same form.
    - 7 Element Order dated prior to the Face to Face exam.

Detailed Product Description Issues (DPD) (18%)

- 4% - DPD not received.
- 14% (total) - For the following :
    - DPD dated before the 7 Element Order.
    - DPD did not match billed claim K0823 was billed; K0840 on DPD.
    - DPD is dated after delivery of the PWC.
    - DPD does not match billed services.

Delivery Ticket Issue (9%)

- 6% - No delivery ticket.
- 3% - Delivery ticket does not match claim date of service.

LCMP Specialty Exam issues (7%)

- 7% - Documentation lacks financial attestation statement.

Home Assessment Issues (7%)

- 4% - Documentation did not include evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair, (PWC).
- 3% - Documentation of the denied claims were not signed and dated by either the supplier or the practitioner.

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: Date of Service 4-27-12, K0823

Received: DPD, 7 Element Order, and Home Assessment.

Missing: Face to Face, Specialty Exam, and Proof of Delivery. Unable to determine the medical necessity of the wheelchair request, or if the beneficiary received it.

Example 2: Date of Service 5-21-12, K0823

Received: 7 Element order, Face to Face exam, DPD, Specialty Exam and Financial Attestation, Home Assessment, and Proof of Delivery.

Missing: Signature stamps were used on 7 Element order and Face to Face exam, which are not acceptable per the *Medicare Program Integrity Manual* (PIM) Chapter 3.

Example 3: Date of Service 04/20/12, K0823

Received: DPD received, but was incomplete.7 Element order, but also incomplete.

Missing: Documentation missing narrative of face to face evaluation with ordering physician. DPD did not indicate it was supplier received prior to delivery of service. 7 Element order did not have a date stamp or equivalent to document receipt date by the supplier. No home assessment. No valid delivery ticket.

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:

- CERT Error Articles
  http://www.medicarenhic.com/dme/dmeduc.shtml

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

- Power Mobility Devices - 7-Element Order (published 11/05/09)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf

- Power Mobility Devices Billing Reminder (published 01/11/08)
  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 07/13/12, published 04/20/12, published 12/15/11, published 08/26/11, published 06/10/11, published 03/11/11, published 11/05/10)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_current.shtml

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

- Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements (Medicare Learning Network; ICN 905063 September 2011)
  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 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 January 01, 2012 through March 31, 2012 and resulted in a 46.7 % Charge Denial Rate (CDR).

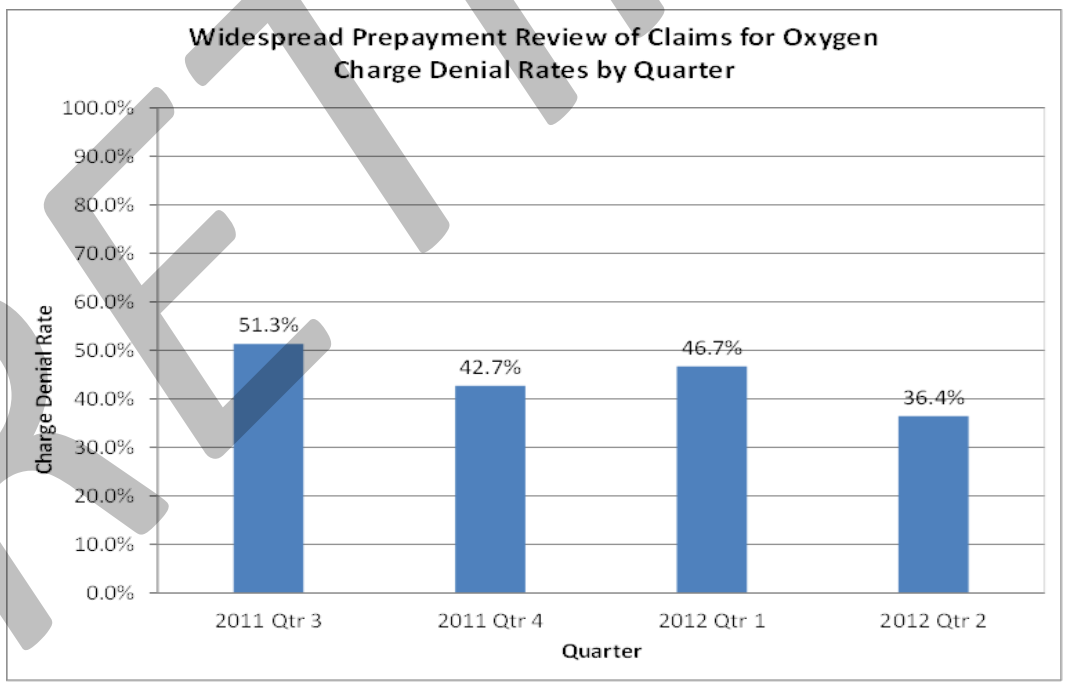
Current Review Results

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 process dates primarily from April 01, 2012 through June 30, 2012.

The review involved prepayment complex medical review of 449 claims submitted by 208 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 142 (31%) of the claims. For the remaining 307 claims, 205 claims were allowed and 102 were denied resulting in a claim denial rate of 33.0%. 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 36.4%.

Charge Denial Rate Historical Data

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



Home oxygen is covered only when both the reasonable and necessary criteria are met. Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptom that might be expected to improve with oxygen therapy, and
2. The patient's blood gas study meet the criteria stated , and
3. The qualifying blood gas study was performed by a physician or qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
    a. If the qualifying blood gas study is performed during an inpatient stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
    b. If the qualifying blood gas study is not performed during an inpatient stay, the reported test must be performed while the patient is in a chronic stable state - i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective

Primary Reasons for Denial

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

Missing Documentation (83%):

Missing required Physician Visit per LCD L11468:

- 59% of the denied claims were missing treating physician visits - 30 days prior to the Initial CMN.

Missing qualifying blood gas study per LCD L11468:

- 24% No documentation to validate oxygen testing.

Missing required Certificate of Medical Necessity per LCD L11468:

- 5.0% Missing an Initial CMN.

Clinical Documentation Issues: Medical Necessity could not be established (13%):

Clinical documentation did not support criteria of LCD L11468 for the following reasons (7%):

- Clinical documentation received did not include indication that patient would benefit from home oxygen therapy as patient was prescribed hand held inhaler only. Written order received.
- Clinical documentation received indicates oxygen to be used on a "prn" basis only.
- Blood gas study (oximetry test) received, no physician clinical notes.

Clinical documentation did not support criteria indicated on CMN for the following reasons (6%):

- Nocturnal testing did not qualify for Group I testing, less than 5 minutes recorded of desaturation.
- Medical documentation received did not include blood gas study. Written order only was received indicating an oxygen saturation level meeting Group I level criteria.

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: DOS 1/20/12 billed: E0431

Documentation received: written order (illegible), referral/intake form, initial CMN dated 1/20/12, oxygen test results dated 1/19/12, valid delivery ticket, various hospital admission forms, and physical therapy evaluation form.
Missing: Treating physician visit 30 days prior to initial CMN - no documentation from the treating physician that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.

Example 2: DOS 1/25/12 code(s) billed: E1390, E0431

Documentation received: written order, valid initial CMN dated 1/25/12, inpatient laboratory results, inpatient physician treating notes ; within 2 days from discharge, valid delivery ticket .
Missing: supporting clinical documentation. Discharge physician summary report received, with no indication of physician determining that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.

Example 3: DOS 1/13/12-3/13/12 , code(s) billed: E1390, E0431

Documentation received: written order, initial CMN (difficult to read) dated 1/13/12, patient demographic sheet, delivery ticket to patient's hospital room, supplier orientation sheet.

Missing: supporting clinical documentation. 1. The treating physician clinical documentation which has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy. 2. The qualifying blood gas study performed which was obtained closest to, but no earlier than 2 days prior to the hospital discharge date.

Next Step

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

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

Educational References

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

Suppliers are encouraged to review the following references:

- The Oxygen and Oxygen Equipment Local Coverage Determination (LCD); L11468 and related Policy Article (A33768)
  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.

- CERT Error articles - Monthly Publications
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

- 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: June 29, 2012, March 2, 2012, November 4, 2011, August 26, 2011, November 5, 2010, and June 9, 2010)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

Surgical Dressings - Benefit Category Reminder (SPE)

Recently questions have arisen regarding the use of surgical dressings for Medicare beneficiaries. Surgical dressings are afforded limited coverage by Medicare as defined in the Centers for Medicare & Medicaid Services (CMS) *Benefit Policy Manual* (Internet-only Manual, Publ. 100-2). Chapter 15, Section 100 of the *Benefit Policy Manual* provides details for coverage of surgical dressings under this benefit:

Surgical dressings are limited to primary and secondary dressings required for the treatment of a wound caused by, or treated by, a surgical procedure that has been performed by a physician or other health care professional to the extent permissible under State law. In addition, surgical dressings required after debridement of a wound are also covered, irrespective of the type of debridement, as long as the debridement was reasonable and necessary and was performed by a health care professional acting within the scope of his/her legal authority when performing this function. Surgical dressings are covered for as long as they are medically necessary.

Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. Items such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings. Elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are examples of items that are not ordinarily covered as surgical dressings. Some items, such as transparent film, may be used as a primary or secondary dressing.

As a result of this restrictive language, not all wounds are eligible for surgical dressing reimbursement. To be eligible for coverage, at least one of the two following key statutory requirements must be met:

1) The wound must be surgically-created or surgically-modified; or,
2) The wound requires debridement.

The DME MAC Surgical Dressings Local Coverage Determination and related Policy Article provides additional examples of situations (not all-inclusive) in which dressings are statutorily excluded from coverage under the Surgical Dressings benefit:

a. Drainage from a cutaneous fistula which has not been caused by or treated by a surgical procedure; or,
b. A Stage I pressure ulcer; or,
c. First degree burn; or,
d. Wounds caused by trauma which do not require surgical closure or debridement - e.g., skin tear or abrasion; or,
e. A venipuncture or arterial puncture site (e.g., blood sample) other than the site of an indwelling catheter or needle.

There must be sufficient information in the beneficiary's medical record regarding the wound(s) (e.g., etiology, size, depth, tunneling/undermining, exudate/escar characteristics, prior treatments) to allow the DME MAC's review staff to determine that the wound(s) meet the applicable statutory coverage criteria. In some instances, it may be clinically appropriate to utilize a particular dressing to treat a wound; however, unless the statutory benefit category requirements for surgical dressings described above are met, Medicare coverage for the surgical dressing is precluded. Claims for surgical dressings that do not meet the statutory benefit requirements will be denied as non-covered (no benefit).

Note that if the above statutorily-excluded dressings are billed to Medicare, they must have appended a GY modifier, indicating no Medicare benefit. This statutory exclusion and need for a GY modifier also applies to dressings used for similar situations such as abrasions, cuts, friction tears, ruptured bullae, self-inflicted wounds, "moisture-acquired skin defects" and similar wounds unless they are either (a) caused by or the result of a surgery or (b) documented in the record to have required surgical debridement.

Gradient compression stockings merit additional caution. According to CMS, gradient compression stockings that serve a therapeutic or protective function and that are needed to secure a primary dressing may be covered as surgical dressings. The gradient stocking must be proven to deliver compression greater than 30 mm Hg. and less than 50 mm Hg. In addition to these requirements, the basic benefit category requirement of use to treat a surgically-created or surgically-treated wound must still be met. Consequently, Medicare limits the coverage and reimbursement of gradient compression stockings to the following situation:

- The beneficiary must have an open venous stasis ulcer that **has been treated by a physician or other healthcare professional *requiring medically necessary debridement.*** [Emphasis added]

Additionally, CMS provides guidance on situations where gradient compression stockings are non-covered:

- Venous insufficiency without stasis ulcers
- Prevention of stasis ulcers
- Prevention of the reoccurrence of stasis ulcers that have healed
- Treatment of lymphedema in the absence of ulcers

When a covered gradient compression stocking is provided to a patient with an open venous stasis ulcer, the modifier AW (item furnished in conjunction with a surgical dressing) must be appended or the claim will be denied as a non-covered service.

Finally, note that many of the citations above reference documentation of treatment by the physician or other healthcare professional. Suppliers are reminded that the CMS *Program Integrity Manual* (Internet-only Manual, Chapter 5) in Section 5.7 states (in part):

> *However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable).*

Suppliers should refer to the Surgical Dressings LCD and related Policy Article for additional coverage, coding and documentation requirements.

Customer Service should be your first means of contact for any questions or issues you have that cannot be addressed by the IVR. You can speak with a Customer Service Representative directly at the following number:

866-590-6731

Ask-the-Contractor Teleconference (ACT) Q&A - September 19, 2012 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Wednesday, September 19, 2012 as a teleconference/webinar and was based on the Recovery Auditor, Performant Financial, process and procedures. A brief presentation was provided followed by an operator assisted Q&A session.

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

Q1: Claims are being recouped from 2009 and we did not know the patient is in the hospital. How do we handle this?
A1: Suppliers should be contacting their patient's periodically to ensure the beneficiary is at home and continuing to use the equipment provided. Also, suppliers are able to file an appeal with their DME MACs if they feel the claim was denied/recouped in error.

Q2: What is the timeframe on how far back the Recovery Auditor will review claims?
A2: Three years back from the original paid date. Not necessarily the calendar date, however; it is based on the paid date by Medicare.

Q3: How do you contact the Recovery Auditor executive staff?
A3: There is a list of contact information within the presentation.

Q4: We delivered equipment to the hospital the day of discharge; however, the patient was not discharged until a day later?
A4: Per Chapter 4 of the CMS *Program Integrity Manual*: "supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to 2 days prior to the patient's anticipated discharge to their home." The PIM only allows for delivery up to two days prior to discharge. If there is an unexpected delay in discharge they may have to pick up and re deliver if the delay is prolonged (Undefined). A short delay would merely need a clear explanation in the record.

Q5: We are having difficulty obtaining medical records from the physician's office. What can we do?
A5: The "Dear Physician" letters will assist in this process or have the patient get involved and contact the physician's office requesting their records. Also, we suggest you obtain this information prior to claim submission in order to determine that you have all required documentation upfront.

Q6: Medical record payments that are paid every 25 days. Does the provider have to submit an invoice for that or is it automatic?
A6: No, the provider does not have to submit an invoice. The Recovery Auditor will run queries every 30 days to validate how many pages of medical records have been received. A letter is sent out along with the check and a detailed listing of all the beneficiaries whose medical records were submitted. The Recovery Auditor will not pay off of an invoice.

Q7: We sent an attestation statement to the physician and they do not want to sign it if they have not seen the patient on that day. How do you handle that, do you put in a range of dates?
A7: For attestation statements, there is a date field on the form to indicate the time frame of the records.

Q8: Take backs for a person in a nursing home or hospital on a rental period date. If oxygen is consistently billed for 36 months and you lose this month's rental due to the patient in a SNF or hospital, is there any way to bill for a partial month?
A8: If there is still any billable dates within that month, you don't have to bill for a partial month.
Example: If the money was taken back for the 15th, which is your normal billing date, and they were discharged on the 20th, then the 20th will be your billing date and for every month thereafter. If you do not have a timely date of service to bill, you can bill the most recent payable date of service and obtain your monthly payment.

Q9: **What documentation is needed for Recovery Audits? Can we have our ABN and delivery slip on the same form with just the one signature for both?**
A9: No, the ABN and delivery slip must be separate documents since the ABN is a standard CMS Form.

Q10: **Do items statutorily excluded from Medicare need to have a delivery slip?**
A10: No, however, if you are billing an item to Medicare, a delivery slip is required.

Q11: **In the event a patient caps in 2010 for a wheelchair, thirteen months have paid and the patient is now deceased, then two and a half years later, money is recouped for the patient being in a skilled nursing facility, how do we handle this?**
A11: Ensure you are contacting your patient monthly to determine if they are in a facility or have stopped using the equipment. This is one way to prevent this type of recoupment from occurring in the first place. You can appeal the claims if there is a billable date of service within the month or a month to add on to the end of the rental, however, if there is not a billable date, you will not be reimbursed.

Q12: **How do I ensure the documents received from the physician's office are legible?**
A12: Suppliers need to educate the physicians on the documentation requirements of Medicare and legibility is a key component.

Q13: **When an item is being replaced, and it hasn't met the 5 year useful lifetime, is it advisable to get an ABN and have the patient sign?**
A13: If the item is being replaced due to wear and tear, you will want to get an ABN. However, if an item is irreparably damaged, lost, or stolen, Medicare will consider reimbursement of that item and an ABN is not necessary.

Q14: **If Medicare doesn't know a patient is in the hospital or Skilled Nursing Facility, how are suppliers expected to know?**
A14: The reason we expect suppliers to know it that suppliers should be checking with their patient's to ensure they are home and still using the equipment. Medicare does not know if a patient is in one of these facilities until Part A has billed for these services.

Q15: **How do I locate the "Dear Physician" letters on NHIC's website?**
A15: They can be found on the NHIC's Web site at: **http://www.medicarenhic.com/dme/phy_letters.shtml**

Q16: **Can an ABN be issued if the patient did not notify the supplier of their admission to a SNF or hospital?**
A16: No, there are limited reasons for issuing an ABN in which CMS governs. You cannot charge private pay to a patient if they do not advise you of their admission to a facility. You should advise the patient or caregiver on the intake process that they need to contact the supplier in the event they are admitted to a facility.

Q17: **For delivery in anticipation of discharge from a hospital or SNF, is there clarification of what is considered a "short delay"?**
A17: This information can be found in the following link of FAQs from the CERT Task Force webinar conducted December 2011; **http://www.medicarenhic.com/dme/CERT/1211_CERT_Taskforce_QA.pdf**. The answer is listed under question 22 under the subject "Proof of Delivery. There is no specific definition. We suggest picking up the equipment if the delay will be more than a few days.

Q18: **When we are billing PEN pumps for denial and have a valid ABN on file, are we still obligated to send the rent/purchase option letter even though Medicare is not going to make payment?**
A18: Yes, even though it is being billed for a denial, all Medicare rules need to be followed. The rent/purchase letter/option can be provided upfront for PEN pumps since the equipment can be purchased at any time during the rental.

Q19: **If a patient is seen by a home physician service and the nurse performs the pulse oximitry, is this considered a qualifying test as long as the nurse is working under the office of the physician?**
A19: If they are not able to bill the A/B MAC for this test, then they are not considered a qualified provider of this service. If there is any doubt on who is considered qualified to perform the test, providers will want to contact their A/B MAC to get clarification.

Q20: **Where is the list of A/B MAC Contractors?**
A20: The CMS web site includes a database which can be searched for the appropriate A/B MAC. The database is available at: **http://www.cms.gov/apps/contacts/default.aspx**

Q21: **The patients are in a skilled nursing facility and exhausted their Part A stay. We are now billing the DME MACs since they are not Part B. The Recovery Auditors are recouping monies incorrectly. How do we handle this?**
A21: The Recovery Auditor will review this issue.

Q22: **If the medical record is not legible and the physician decides he will go back and transcribe his records, is this acceptable?**
A22: Most lawyers will say that records should never be altered once they are done. Since Medicare uses the same legal standards, I think it would raise a lot of questions about potentially falsified records were this to be done.

Q23: **Regarding the documentation from the physician as to why a patient needs a replacement breast form. If the physician saw the patient in January and the patient needs the form in June, is another physician visit required?**
A23: For "Non-Consumable" items, documentation is required to explain why the item is needed. It doesn't necessarily have to be from the physician, it can be documented by the provider. If a new item is required because their current item is torn, etc. the supplier can document why the item needs to be replaced. As with mastectomy bra's, if they are worn out, it needs to be documented why they are being replaced. A new order would be required for the replacement item.

Q24: **If a claim is denied by the Recover Auditor for the patient being in a facility on the date of service billed, but it is only off by one day, will this be eligible for discussion amongst the RA's or will it need to go to an appeal?**
A24: This can be part of the discussion period and based on the documentation, the RAs can review and determine if it will be overturned or upheld.

Q25: **Regarding criteria 2 of RAD devices, does the hypopnea refer to central hypopneas or all hypopneas?**
A25: Central sleep apnea (CSA) is defined as:

1. An apnea-hypopnea index (AHI) greater than 5, and
2. Central apneas/hypopneas greater than 50% of the total apneas/hypopneas, and
3. Central apneas or hypopneas greater than or equal to 5 times per hour, and
4. Symptoms of either excessive sleepiness or disrupted sleep.

In #2 the first mention is for central and the second is for total.

Q26: **The patient had a visit with their physician and had a sleep study; however, the physician was then incarcerated and the patient records cannot be obtained. We are now being audited and unsure what to do in this situation?**
A26: Your claims will be denied because you do not have the records. However, you can try to appeal. This is why we suggest obtaining the records upfront to avoid these types of situations.

Q27: **Regarding diabetic shoes, on the diagnosis, should we be using the diabetic code from the prescribing physician or the certifying physician?**
A27: The diagnosis would need to come from the certifying physician.

Billing Reminder: Narrative Requirements for Supplies and Accessories Used with Beneficiary Owned Equipment (GEN)

Suppliers are reminded that additional documentation is required in situations where supplies and accessories are provided for a piece of equipment not paid for by Fee-For-Service (FFS) Medicare. In addition, drugs used with a nebulizer or external infusion pump would be considered supplies to a covered piece of DME and must meet the same documentation requirements outlined below.

For supplies and accessories used with equipment purchased privately or by another insurer, all of the following information must be submitted with each claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

- HCPCS code of base equipment; **and**
- A notation that this equipment is beneficiary-owned; **and**
- Date the patient obtained the equipment (Month and Year at a minimum)

Example narratives for nebulizer drugs and supplies used with a beneficiary owned nebulizer:

BENEFICIARY OWNED E0570 PURCHASED MAY 2007

or

PO E0570 DOP MAY 2007

Example narrative for CPAP supplies for a beneficiary owned CPAP:

BENEFICIARY OWNED E0601 PURCHASED JUNE 2005

or

PO E0601 DOP June 2005

A suggested list of abbreviations is available at: **http://www.medicarenhic.com/dme/edi/sugg_abbre.pdf**

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be denied for missing information.

Claims denied for missing information on the base piece of equipment may be submitted to written reopenings with the required documentation. If a claim for the base piece of equipment was subsequently submitted after the claim for the supplies and/or accessories denied; the claim can be corrected via the telephone reopenings process.

Suppliers can verify payment or record of the base piece of equipment by accessing the CMN Status Option 3 in the Interactive Voice Response (IVR) System.

The *IVR User Guide* (**http://www.medicarenhic.com/dme/contacts/DME_MAC_A_IVR_User_Guide.pdf**) is available to assist in this process.

Important Clarification: *This documentation must be present on every claim (not only the 1st claim) for supplies and accessories used with beneficiary owned equipment which was not paid for by FFS Medicare.*

Electronic Remittance Advice Formatting Concerns (GEN)

The Centers for Medicare & Medicaid Services issued a Medicare Learning Network Matters article 7499 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7499.pdf**), titled "*Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number*"; the implementation date for supplier submitted claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) was October 01, 2012.

CMS determined 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.) and that would subsequently reduce the costs for providers as well as Medicare.

Since the implementation of this change the DME MACs have received calls from suppliers who indicate their electronic remittance advices (ERAs) are not formatting correctly. On October 08, 2012 the Common Electronic Data Interchange (CEDI) sent a reminder to the supplier community to upgrade to the 3.3 version of Medicare Remit Easy Print (MREP) so their ERAs will format correctly.

If you are a DMEPOS supplier who is encountering this problem, you should be aware that this is not a DME MAC issue but rather an issue with supplier software. Suppliers should contact their software vendors or clearinghouses to have their software updated as soon as possible so that their remits will format properly.

Note: *If you received an ERA that was not properly formatted because your software was not updated, once updated suppliers can simply reprint the ERA. There is no need to contact the DME MACs.*

This does not apply to suppliers who continue to receive standard paper remits.

PWK Segment (GEN)

Beginning October 01, 2012, Suppliers will have the option of mailing or faxing hard copy documentation to accompany their electronically-submitted DMEPOS claims. **Use of the PWK segment is completely voluntary and does not guarantee that the DME MAC will review the submitted paperwork.** When processing claims, the DME MAC may look for additional information in the NTE segment or the PWK segment in order to complete the claim; however, use of the PWK segment does not mean that the DME MAC will always review the information. The DME MAC will only look at the additional information when needed in order to properly process payment.

DME MAC Jurisdiction A encourages suppliers to continue to use the NTE segment if that method of conveying additional information for your claim submissions has been effective.

If a supplier chooses to submit information using the PWK process:

1. The electronic claim is submitted, completing the PWK segment (use **BM** if mailing the documentation, or **FX** if faxing)
2. After the claim has been accepted by CEDI, complete the *PWK Fax/Mail Cover Sheet*, available on the CMNs and Forms page of the DME MAC A web site
3. Fax or mail the *PWK Cover Sheet* with all necessary documentation
    - Medicare contractors will allow seven calendar "waiting" days (from the date of receipt) for additional information to be faxed or ten calendar "waiting" days for additional information to be mailed
4. The DME MAC will process the claim and will refer to the submitted PWK documentation, if needed, for proper claim adjudication

When considering whether or not to use the PWK segment, please keep the following tips in mind:

- **Use of the PWK segment is entirely voluntary**
    - Suppliers are not required to use the PWK segment in any circumstance; it is entirely voluntary. Under current claim processing rules, if a Medicare contractor determines that additional information is needed to complete proper adjudication of a claim (for instance, due to an audit), then the contractor will send you a development letter requesting additional documentation. This process will not change. If you believe the claim may result in a development request, then it may be a good idea to include the documentation through the PWK process in order to expedite claim processing time. Please keep in mind that most often; claims are randomly selected for audits so a supplier would not necessarily know in advance that a claim will be selected for a prepayment review.

- **The NTE field is still the best option to submit additional information**
    - Using the PWK segment is not always the best option for including additional claim information. The NTE (note) segment of an electronic claim is currently available for you to include notes and information that may be important for the proper adjudication of the claim. The NTE segment will continue to be available.

  Use of the PWK segment results in additional processing time due to the waiting period required for us to receive your mailed/faxed documentation. If you can use the NTE segment instead of the PWK segment, we encourage you to do so.

- **Use of the PWK segment does not guarantee that the DME MAC will review the submitted paperwork**
    - When processing your claims, NHIC, Corp. DME MAC may look for additional information in the NTE segment or the PWK segment (beginning October 1) in order to complete the claim; however, use of the NTE segment or PWK segment does not mean the information will always be reviewed. The additional information will only be reviewed when needed in order to properly process payment. For instance, if a claim is submitted with a modifier that precludes payment for the item, the claim will deny without our claim processors looking at the NTE or PWK segments.

- **Do not send PWK documentation unless it is needed**
  - Medicare rules and regulations require that suppliers keep certain documentation on file in order to support the medical necessity and justification of your claims (detailed written orders, proof of delivery, etc.); however, you are not required to submit this documentation with your claim. We encourage you to only submit supporting claim documentation when you believe we require it in order to correctly process the claim.

The *DME PWK Coversheet* is available on the CMNs and Forms section of the NHIC, Corp. DME MAC web site at: **http://www.medicarenhic.com/dme/dme_forms.shtml#Forms**

Additional information about the use of the PWK segment is available in:

- MLN Matters Article MM7041 - **http://www.cms.gov/MLNMattersArticles/downloads/MM7041.pdf**
- MLN Matters Article MM7306 - **http://www.cms.gov/MLNMattersArticles/downloads/MM7306.pdf**

Termination of the Common Working File Eligibility (ELGB) Provider Query (GEN)

Medicare providers currently use the Common Working File (CWF) ELGB query to confirm Medicare beneficiary eligibility. This CWF ELGB query is accessed via the VIPs Provider Inquiry Query (VPIQ) system, commonly known as Claim Status Inquiry (CSI), to obtain beneficiary eligibility.

Effective April 01, 2013 the Centers for Medicare and Medicaid Services (CMS) must eliminate this query capability. The information is not HIPAA compliant because the incoming query and the outgoing response are not in X12 format. Therefore, CMS can no longer support allowing providers online access to CWF non-HIPAA compliant data. Additional information is available at: **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8086.pdf**

Beneficiary eligibility information will remain available via the Provider Services Portal (PSP).

Additional information about the PSP is available at:
http://www.medicarenhic.com/dme/dme_psphome_index.shtml
or contact the PSP Helpdesk at 781-741-3192 to speak to a representative.

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

Third Quarter 2012 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for July through September 2012 are provided in the following table.

Note: *The data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. The edits listed are in version 5010A1.*

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 - Rejected for relational field Information within the HCPCS	122,741	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.121.2010BA.NM109.020 -Invalid Information for a Subscriber's contract/member number	31,425	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
X222.087.2010AA.NM109.050 -Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	24,074	The NPI submitted is not linked to the Submitter ID under which the claim file was sent. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site and return to CEDI for processing.
X222.094.2010AA.REF02.050 -Relational field Billing Provider NPI and Tax ID	20,759	Billing Provider Tax Identification Number must be associated with the billing provider's NPI. Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.380.2400.DTP03.090 -Invalid Information within the Date(s) of service	20,612	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.
X222.087.2010AA.NM109.030 -Invalid information in the Billing Provider's NPI	17,980	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.380.2400.DTP03.080 -Invalid Information within the Future date and Date(s) of service	17,837	The service start/from date is greater than the date this claim was received.
X222.351.2400.SV101-7.020 -Missing Information within the Detailed description of service	16,357	The narrative information is missing. The procedure code submitted requires narrative information.
X222.226.2300.HI01-2.030 -Invalid Information within the Primary diagnosis code	14,170	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
X222.157.2300.CLM02.090 -This Claim is rejected for Invalid Information on an MSP claim	13,386	The total claim level and line level adjustment amounts plus the primary paid amount must equal the total for all submitted charges.

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 table and share it with your colleagues.

DME MAC A's Gift Policy (GEN)

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

2013 Jurisdiction A DME MAC Holiday Schedule (GEN)

The **Jurisdiction A Offices** will be observing the following holidays in 2013:

Holiday	Day of the Week	Date
New Year's Day	Tuesday	January 1
Martin Luther King, Jr. Day	Monday	January 21
Memorial Day	Monday	May 27
Independence Day	Thursday	July 4
Labor Day	Monday	September 2
Veteran's Day	Monday	November 11
Thanksgiving Day	Thursday	November 28
Friday following Thanksgiving	Friday	November 29
Company-designated Floating Holiday	Tuesday	December 24
Christmas Day	Wednesday	December 25

The **Jurisdiction A Call Center** will be observing the following holidays in 2013:

Holiday	Day of the Week	Date
New Year's Day	Tuesday	January 1
Martin Luther King, Jr. Day	Monday	January 21
Memorial Day	Monday	May 27
Independence Day	Thursday	July 4
Labor Day	Monday	September 2
Columbus Day	Monday	October 14
Thanksgiving Day	Thursday	November 28
Day after Thanksgiving	Friday	November 29
Christmas Day	Wednesday	December 25

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/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html**. CMS encourages you to bookmark this Web site and visit it often for this valuable information.

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**

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 September of 2012 chapters 1, 2, 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.

Updating Supplier Records (GEN)

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

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

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

For instructions on the completion and mailing of CMS-855S, visit the CMS Forms web site at **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html** to download the Form.

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

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey (GEN)

NHIC, Corp. DME MAC Jurisdiction A is committed to ensuring that our Web site meets the needs of our users. We continually strive to improve our offerings based on the information and feedback we receive from you. In order to accomplish this, we offer *The DME MAC A Web site Customer Satisfaction Survey*. This survey is designed to collect information that helps measure providers' satisfaction with contractors' Web sites with a focus on customer service.

If you see the **Customer Satisfaction Survey** pop up while you are browsing the DME MAC A Web site, please take a moment to participate. Completion should only take a few minutes.

As our site is constantly changing, we would appreciate your input! We are listening... It is **your** feedback that makes those changes possible!

Thank you for taking the time to provide us with your comments! Remember, it is your feedback that makes changes possible in order to address your Medicare needs!

Quiz yourself and your staff

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

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

Outreach-education@hp.com

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: *Include both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Faxed Reopenings: 781-741-3914

Redetermination Requests Fax: 781-741-3118

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

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

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

LCD Reconsiderations Mailing Address:
Same as Draft LCDs Comments

Draft LCDs Comments Email Address:
NHICDMEDraftLCDFeedback@hp.com

LCD Reconsiderations Email Address:
NHICDMELCDRecon@hp.com

LCD Reconsiderations Fax: 781-741-3991

ADMC Requests

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

ADMC Requests Fax:
Attention: ADMC
781-741-3991

Common Electronic Data Interchange (CEDI)

Help Desk: 866-311-9184

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

DME MAC Jurisdiction A Resource

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

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Publication Information

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

Visit the following websites for more information:

NHIC, Corp.: www.medicarenhic.com/dme

TriCenturion: www.tricenturion.com

CMS: 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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