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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction (MM7679) (GEN)

MLN Matters® Number: MM7679
Related CR Release Date: March 23, 2012
Related CR Transmittal #: R2427CP
Related Change Request (CR) #: 7679
Effective Date: January 1, 2012
Implementation Date: April 23, 2012

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Medicare contractors (Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Part B carriers, and A/B MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is informational and based on Change Request (CR) 7679 that notifies suppliers that the spreadsheet containing an updated list of HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staffs by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2012 Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at **http://www.cms.gov/center/dme.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

Note that as part of the 2012 update, HCPCS codes L8511, L8512, L8513, L8514, and L8515 are changing claims processing jurisdiction from DME MAC to joint local carrier and DME MAC jurisdiction. To facilitate the jurisdiction change, carriers and A/B MACs will manually price claims for codes L8511 through L8515 with dates of service on or after January 1, 2012, using the 2012 DMEPOS fee schedule amounts found in Attachment B of CR7679.

Additional Information

The official instruction, CR7679, issued to your Medicare A/B MAC, carrier, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2427CP.pdf** on the CMS website. **The 2012 Jurisdiction List and Attachment B showing the 2012 DMEPOS fee schedule amounts for HCPCS codes L8511, L8512, L8513, L8514, and L8515 are attached to CR7679.**

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

Assigned Codes for Home Oxygen Use for Cluster Headache (CH) in a Clinical Trial (ICD-10) (MM7820) (OXY)

MLN Matters® Number: MM7820
Related CR Release Date: May 11, 2012
Related CR Transmittal #: R2465CP
Related Change Request (CR) #: CR 7820
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for providing home use of oxygen services to Medicare beneficiaries.

Provider Action Needed

Impact to You

Effective for claims with dates of service on or after October 1, 2012, your DME MAC will pay for home use of oxygen for the treatment of Cluster Headaches (CH) during the 36 month rental period, if the claims contain all of the codes and modifiers described in the Background Section below.

What You Need to Know

Change Request (CR) 7820, from which this article is taken, provides the oxygen codes and modifiers that will be used, effective October 1, 2012, to identify home use of oxygen for CH provided in a Medicare approved clinical study under Coverage with Evidence Development (CED) pursuant to the "*National Coverage Determinations Manual*," Chapter 1, Part 4 (Sections 200 - 310.1) Coverage Determinations, Section 240.22 (Home Oxygen Use to Treat Cluster Headache (CH) - (Effective January 4, 2011)).

What You Need to Do

You should make sure that your billing staffs are aware of these codes and modifiers for home use of oxygen for CH.

Background

On January 14, 2011, the Centers for Medicare & Medicaid Services (CMS) released CR7235, "Home Use of Oxygen to Treat Cluster Headache (CH)," effective January 4, 2011, to be implemented February 14, 2011. (You can find the associated MLN Matters® Article at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//MM7235.pdf** on the CMS website).

CR7235 explained that effective for claims with dates of service on or after January 4, 2011, Medicare will allow for coverage of home use of oxygen to treat Medicare beneficiaries diagnosed with CH when those beneficiaries are enrolled in CMS approved clinical studies, for the purpose of gaining further evidence. The clinical studies must: 1) Compare normobaric 100% oxygen with at least one clinically appropriate comparator for the treatment of CH, and 2) Address whether the home use of oxygen improves Medicare beneficiaries' health outcomes in compliance with the criteria in the "*Medicare National Coverage Determinations Manual*," Chapter 1, Part 4 (Sections 200 - 310.1) Coverage Determinations, Section 240.2.2 (Home Oxygen Use to Treat Cluster Headache (CH) (Effective January 4, 2011)) which you can find at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//ncd103c1_Part4.pdf** on the CMS website.

The following oxygen codes and modifiers will be used, effective October 1, 2012, to identify home use of oxygen for CH, provided pursuant to a Medicare-approved clinical study under Coverage with Evidence Development (CED):

Code	Description
E0424	Stationary Compressed Gaseous Oxygen System, Rental; Includes Container, Contents, Regulator, Flowmeter, Humidifier, Nebulizer, Cannula or Mask, and Tubing
E0441	Stationary Oxygen Contents, Gaseous, 1 Month's Supply = 1 Unit
E0443	Portable Oxygen Contents, Gaseous, 1 Month's Supply = 1 Unit

Modifier	Description
QF	Prescribed Amount of Oxygen Exceeds 4 Liters Per minute (LPM) and Portable Oxygen is Prescribed
QG	Prescribed Amount of Oxygen is Greater than 4 Liters Per Minute (LPM).

Please note that for the treatment of CH, this policy refers to the use of gaseous oxygen equipment and contents only. Further, the usual dosage of oxygen for the treatment of CH is between 6-12 liters per minute. Modifiers "QG" or "QF" will be used with E0424 to adjust the monthly stationary oxygen payment amount to recognize that oxygen is prescribed for CH at a rate that exceeds 4 liters per minute. Therefore, during the 36 month rental period:

- If the beneficiary is prescribed stationary gaseous oxygen at a rate that exceeds 4 LPM, suppliers use the modifier "QG" with Healthcare Common Procedure Coding System (HCPCS) code E0424 to increase the monthly stationary oxygen payment amount by 50 percent.
- If the beneficiary is prescribed both stationary and portable gaseous oxygen at a rate that exceeds 4 LPM, suppliers use the modifier "QF" with HCPCS code E0424 to increase the monthly stationary oxygen payment amount by 50 percent in accordance with the payment rules found in the "*Medicare Claims Processing Manual*," Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)), Section 130.6 (Billing for Oxygen and Oxygen Equipment), which you can find at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//clm104c20.pdf** on the CMS website. A separate monthly payment is not allowed for the portable gaseous oxygen equipment described under HCPCS code E0431.

Payment for Oxygen Contents

Beginning with dates of service on or after the end date of service for the month representing the 36th payment for code E0424, suppliers may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable). If only stationary gaseous oxygen equipment was furnished in month 36 and billed with code E0424, suppliers may bill on a monthly basis for stationary oxygen contents using HCPCS code E0441. However, if both gaseous stationary and portable oxygen equipment were furnished in month 36 and billed using code E0424 "QF", suppliers may bill on a monthly basis for both stationary and portable oxygen contents using HCPCS codes E0441 and E0443.

Additional Billing Information

Specifically, DME MACs will pay claims with dates of service on or after October 1, 2012, for home use of oxygen for the treatment of Cluster Headaches (CH) **during** the 36 month rental period, if they contain all of the following:

- HCPCS code E0424; and Modifier "QF" or "QG" **and** modifier Q0 (clinical trial); and
- ICD-9 diagnosis code 339.00, 339.01, or 339.02; and
- ICD-9 diagnosis code V70.7; and
- POS 12 (home)

Adding the 8-digit clinical trial number is optional.

DME MACs will pay claims with dates of service on or after October 1, 2012, for home use of oxygen for the treatment of Cluster Headaches (CH) **after** the 36 month rental period, if they contain all of the following:

- HCPCS code E0441 and/or E0443; and
- Modifier Q0 (clinical trial); and
- ICD-9 diagnosis code 339.00, 339.01, or 339.02; and
- ICD-9 diagnosis code V70.7; and
- POS 12 (home).

Again, adding the 8-digit clinical trial number is optional.

Effective October 1, 2012, DME MACs will deny claims received with HCPCS code E1399 when billed with ICD-9 diagnosis code(s) 339.00, 339.01, or 339.02. When denying such claims, they will use the following codes:

- Claim Adjustment Reason Code (CARC) 167 - This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code (RARC) N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at **http://www.cms.gov/mcd/search.asp** on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.
- MSN 14.9- "Medicare cannot pay for this service for the diagnosis shown on the claim."
- Group Code CO (Contractual Obligation)

CR7820 also relates the appropriate ICD-10 codes for CH are as follows:

- Cluster Headache ICD-10 diagnosis code(s): G44.001, G44.009, G44.011, G44.019, G44.021, or G44.029; and
- Clinical Trial ICD-10 diagnosis code Z00.6

Additional Information

The official instruction, CR7820, is located at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2465CP.pdf** on the CMS website. If you have any questions, please contact your DME MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), Medicare Remit Easy Print (MREP), and PC Print Update (MM7775) (GEN)

MLN Matters® Number: MM7775
Related CR Release Date: April 6, 2012
Related CR Transmittal #: R2442CP
Related Change Request (CR) #: CR 7775
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

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

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 7775 which updates Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Medicare Remit Easy Print (MREP), and PC Print for Medicare.

What You Need to Know

Change Request (CR) 7775 instructs Medicare contractors and the Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR (CR 7683 Transmittal 2372 published on December 22, 2011). It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software respectively. Be sure your billing staff is aware of these changes.

What You Need to Do Go

If you use the MREP or PC Print software, be sure to download the updated software when available. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The *Health Insurance Portability and Accountability Act* (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions. . For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, valid CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment for Medicare.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages **before** the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR7775, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website is updated only 3 times a year and may not match the CMS release schedule.

CR7775 lists only the changes that have been approved since the last code update CR (CR 7683 Transmittal 2372), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times a year - around March 1, July 1, and November 1 - to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

The WPC website (at **http://www.wpc-edi.com/Reference** on the Internet) has four listings available for both CARC and RARC:

1. **All:** All codes including deactivated and to be deactivated codes are included in this listing.
2. **To Be Deactivated:** Only codes to be deactivated at a future date are included in this listing.
3. **Deactivated:** Only codes with prior deactivation effective date are included in this listing.
4. **Current:** Only currently valid codes are included in this listing.

Note: *In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare.*

Claim Adjustment Reason Code (CARC):

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see **http://www.wpc-edi.com/Reference** on the Internet

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier.. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule.

The following new Claim Adjustment Reason Codes were approved by the Code Committee in January, and must be implemented, if appropriate for Medicare, by July 2, 2012.

New Codes - CARC:

None

Modified Codes - CARC:

Code	Modified Narrative	Effective Date
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	11/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	11/1/2012

Deactivated Codes - CARC:

None

Remittance Advice Remark Codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report

(TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Medicare uses the standard code sets (CARC and RARC) for paper remittance advice as well.

New Codes - RARC:

Code	Code Narrative	Effective Date
N547	A refund request (Frequency Type Code 8) was processed previously.	3/6/2012
N548	Alert: Patient's calendar year deductible has been met.	3/6/2012
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.	3/6/2012
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.	3/6/2012
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.	3/6/2012
N552	Payment adjusted to reverse a previous withhold/bonus amount.	3/6/2012
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	3/6/2012

Modified Codes - RARC:

Code	Modified Narrative	Effective Date
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	3/6/2012
N206	The supporting documentation does not match the information sent on the claim.	3/6/2012

Deactivated Codes - RARC:

None

Additional Information

The official instruction, CR7775, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf** release on the CMS website. If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Claim Status Category and Claim Status Codes Update (MM7793) (GEN)

MLN Matters® Number: MM7793
Related CR Release Date: March 30, 2012
Related CR Transmittal #: R2436CP

Related Change Request (CR) #: CR 7793
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 7793 which explains that 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 to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at **http://www.wpc-edi.com/content/view/180/223/** on the Internet. The

code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012.

Background

HIPAA requires all health care benefit payers to use Claim Status Category Codes and Claim Status Codes to report the status of submitted claim(s). Only codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format are to be used. 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 code sets are available at **http://www.wpc-edi.com/content/view/180/223/** or **http://www.wpc-edi.com/codes** on the Internet. All code changes approved during the June 2012 committee meeting will be posted on that site on or about July 1, 2012. The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by July 2, 2012.

Additional Information

The official instruction, CR7793, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2436CP.pdf** on the CMS website.

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

Clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault and Workers' Compensation (WC) Medicare Secondary Payer (MSP) Claims (MM7355) (GEN)

MLN Matters® Number: MM7355 Revised
Related CR Release Date: May 25, 2012

Related CR Transmittal #: R86MSP

Related Change Request (CR) #: 7355
Effective Date: October 1, 2012 for Professional Claims and DME Supplier Claims; January 1, 2013 for Institutional Claims
Implementation Date: January 7, 2013 for Professional and DME Supplier Claims; January 7, 2013 for Institutional Claims

Note: *This article was revised on May 30, 2012, to reflect the revised CR7355 issued on May 25. In the article, the CR release date, transmittal number, effective and implementation dates (see above), and the Web address for accessing CR7355 were revised. All other information is the same.*

Provider Types Affected

This MLN Matters® article is intended for physicians, hospitals, Home Health Agencies, and other providers who bill Medicare Carriers, Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B/MACs); and suppliers who bill Durable Medical Equipment MACs (DME MACs) for Medicare beneficiary liability insurance (including self insurance), no-fault insurance, and WC Medicare Second Payer (MSP) claims.

Provider Action Needed

This article provides clarifications in the procedures for processing liability insurance (including self-insurance), no-fault insurance and WC Medicare Secondary Payer (MSP) claims. Not following the procedures identified in this article may impact your reimbursement. Change Request (CR) 7355, from which this article is taken, clarifies the procedures you are to follow when billing Medicare for liability insurance (including self-insurance), no-fault insurance, or WC claims, when the liability insurance (including self-insurance), no-fault insurance, or WC carrier does not make prompt payment. It also includes definitions of the promptly payment rules and how contractors will identify conditional payment requests on MSP claims received from you. You should make sure that your billing staffs are aware of these Medicare instructions.

Background

CR7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting Medicare conditional payments on these types of MSP claims.

The term Group Health Plan (GHP) as related to this MLN article means health insurance coverage that is provided by an employer to a Medicare beneficiary based on a beneficiary's own, or family member's, current employment status. The term Non-GHP means coverage provided by a liability insurer (including self-insurance), no-fault insurer and WC carrier where the insurer covers for services related to the applicable accident or injury.

Key Points

Conditional Medicare Payment Procedures

Medicare may not make payment on a MSP claim where payment has been made or can reasonably be expected to be made by GHPs, a WC law or plan, liability insurance (including self-insurance), or no-fault insurance.

Medicare can make **conditional payments** for both Part A and Part B WC, or no-fault, or liability insurance (including self insurance) claims if payment has not been made or cannot be reasonably expected to be made by the WC, or no-fault, or liability insurance claims (including self insurance) and the promptly period has expired. **Note: If there is a primary GHP, Medicare may not pay conditionally on the liability, no-fault, or WC claim if the claim is not billed to the GHP first. The GHP insurer must be billed first and the primary payer payment information must appear on the claim submitted to Medicare.**

These payments are made "on condition" that the trust fund will be reimbursed if it is demonstrated that WC, no-fault, or liability insurance is (or was) responsible for making primary payment (as demonstrated by a judgment; a payment conditioned upon the recipient's compromise, waiver, or release [whether or not there is a determination or admission of liability for payment for items or services included in a claim against the primary payer or the primary payer's insured]; or by other means).

"Promptly" Definition

No-fault Insurance and WC "Promptly" Definition

For no-fault insurance and WC, promptly means payment within 120 days after receipt of the claim (for specific items and services) by the no-fault insurance or WC carrier. In the absence of evidence to the contrary, the date of service for specific items and service must be treated as the claim date when determining the promptly period. Further with respect to inpatient services, in the absence of evidence to the contrary, the date of discharge must be treated as the date of service when determining the promptly period.

Liability Insurance "Promptly" Definition

For liability insurance (including self-insurance), promptly means payment within 120 days after the earlier of the following:

- The date a general liability claim is filed with an insurer or a lien is filed against a potential liability settlement; or
- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

The "*Medicare Secondary Payer (MSP) Manual*" (**http://www.cms.gov/manuals/downloads/msp105c01.pdf**), Chapter 1 (Background and Overview), Section 20 (Definitions), provides the definition of promptly (with respect to liability, no-fault, and WC) which all Medicare contractors must follow.

Note: *For the liability situation, the MSP auxiliary record is usually posted to the Medicare's Common Working File (CWF) after the beneficiary files a claim against the alleged tortfeasor (the one who committed the tort (civil wrong)) and the associated liability insurance (including self-insurance). In the absence of evidence to the contrary, the date the general liability claim is filed against the liability insurance (including self-insurance) is no later than the date that the record was posted on Medicare's CWF. Therefore, for the purposes of determining the promptly period, Medicare contractors consider the date the Liability record was created on Medicare's CWF to be the date the general liability claim was filed.*

How to Request a Conditional Payment

The following summarizes the technical procedures that Part A, and Part B and supplier contractors will use to identify providers' conditional payment requests on MSP claims.

Part A Conditional Payment Requests

Providers of **Part A** services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 Institutional Electronic Claim, using the appropriate insurance value code (i.e., value code 14, 15 or 47) and zero as the value amount. Again, you must bill the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

For hardcopy (CMS-1450) claims, Providers must identify the other payer's identity on line A of Form Locator (FL) 50, the identifying information about the insured is shown on line A of FL 58-65, and the address of the insured is shown in FL38 or Remarks (FL 80). All primary payer amounts and appropriate codes must appear on your claim submitted to Medicare.

For 837 Institutional Claims, Providers must provide the primary payer's zero value code paid amount and occurrence code in the 2300 HI. (The appropriate Occurrence code (2300 HI), coupled with the zeroed paid amount and MSP value code (2300 HI), must be used in billing situations where you attempted to bill a primary payer in non-GHP (i.e., Liability, no-fault and Workers' Compensation) situations, but the primary payer did not make a payment in the promptly period). Note: Beginning July 1, 2012 Medicare contractors will no longer be accepting 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 1 displays the required information of the electronic claim in which a Part A provider is requesting conditional payments.

Table 1
Data Requirements for Conditional Payment for Part A Electronic Claims

Type of Insurance	CAS	Part A Value Code (2300 HI)	Value Amount (2300 HI)	Occurrence Code (2300 HI)	Condition Code (2300 HI)
No-Fault/Liability	*2320 - valid information why NGHP or GHP did not make payment*	14 or 47	$0	01-Auto Accident & Date 02-No-fault Insurance Involved & Date 24-Date Insurance Denied	
WC	*2320 - valid information why NGHP or GHP did not make payment*	15	$0	04-Accident/Tort Liability & Date 24-Date Insurance Denied	02-Condition is Employment Related

Part B Conditional Payment Requests (Table 2)

Since the electronic Part B claim (837 4010 professional claim) does not contain Value Codes or Condition Codes, the physician or supplier must complete the: 1) 2320AMT02 = $0 if the entire claim is a non-GHP claim and conditional payment is being requested for the entire claim; or 2) 2430 SVD02 for line level conditional payment requests if the claim also contains other service line activity not related to the accident or injury, so that the contractor can determine if conditional payment should be granted for Part B services related to the accident or injury.

For Version 4010, Physicians and other suppliers may include CP- Medicare Conditionally Primary, AP-auto insurance policy, or OT- other in the 2320 SBR05 field. The 2320 SBR09 may contain the claim filing indicator code of AM - automobile medical, LI - Liability, LM - Liability Medical or WC - Workers' Compensation Health Claim. Any one of these claim filing indicators are acceptable for the non-GHP MSP claim types.

The 2300 DTP identifies the date of the accident with appropriate value. The "accident related causes code" is found in 2300 CLM 11-1 through CLM 11-3. Note: Beginning July 1, 2012 Medicare contractors will no longer accept 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

Table 2 displays the required information for a MSP 4010 Professional in which a physician/supplier is requesting conditional payments.

Table 2
Data Requirements for Conditional Payments for MSP 4010 Professional Claims

Type of Insurance	CAS	Insurance Type Code (2320 SBR05)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Insurance Type Code (2000B SBR05)	Date of Accident
No-Fault/Liability	2320 or 2430 valid information why NGHP or GHP did not make payment	AP or CP	AM, LI, or LM	$0.00	14	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA, AP or OA
WC	2320 or 2430 valid information why NGHP or GHP did not make payment	OT	WC	$0.00	15	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Please note that for 837 5010 Professional claims, the insurance codes changed and the acceptable information for Medicare conditional payment request is modified as displayed in Table 3.

Table 3
Data Requirements for Conditional Payment for 837 5010 Professional Claims

Type of Insurance	CAS	Insurance Type Code 2320 SBR05 from previous payer(s)	Claim Filing Indicator (2320 SBR09)	Paid Amount (2320 AMT or 2430 SVD02)	Condition Code (2300 HI)	Date of Accident
No-Fault/Liability	2320 or 2430 - valid information why NGHP or GHP did not make payment	14 / 47	AM or LM	$0.00	2300 DTP 01 through 03 and 2300 CLM 11-1 through 11-3 with value AA or OA	
WC	2320 or 2430 - valid information why NGHP or GHP did not make payment	15	WC	$0.00	02-Condition is Employment Related	2300 DTP 01 through 03 and 2300 CLM 11-1 through or 11-3 with value EM

Note: *Medicare beneficiaries are not required to file a claim with a liability insurer or required to cooperate with a provider in filing such a claim, but they are required to cooperate in the filing of no-fault claims. If the beneficiary refuses to cooperate in filing of no-fault claims Medicare does not pay.*

Situations Where a Conditional Payment Can be Made for No-Fault and WC Claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates the no-fault insurance or WC is involved for that specific item or service;
- There is/was no open GHP record on the Medicare CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the no-fault insurer or WC entity first; and

- There is information on the claim that indicates the no-fault insurer or WC entity did not pay the claim during the promptly period.

Note: *When a conditional payment is made to you, Medicare contractors will use Remittance Advice Remark Code M32 to indicate a conditional payment is being made.*

Situations Where a Conditional Payment Can be Made for Liability (including Self Insurance) Claims

Conditional payments for claims for specific items and service may be paid by Medicare where the following conditions are met:

- There is information on the claim or information on Medicare's CWF that indicates liability insurance (including self-insurance) is involved for that specific item or service;
- There is/was no open GHP record on the Medicare's CWF MSP file as of the date of service;
- There is information on the claim that indicates the physician, provider or other supplier sent the claim to the liability insurer (including the self-insurer) first, and
- There is information on the claim that indicates the liability insurer (including the self insurer) did not make payment on the claim during the promptly period.

Conditional Primary Medicare Benefits Paid When a GHP is a Primary Payer to Medicare

Conditional primary Medicare benefits may be paid if the beneficiary has GHP coverage primary to Medicare and the following conditions are **NOT** present:

- It is alleged that the GHP is secondary to Medicare;
- The GHP limits its payment when the individual is entitled to Medicare;
- The services are covered by the GHP for younger employees and spouses but not for employees and spouses age 65 or over; • If the GHP asserts it is secondary to the liability (including self insurance), no-fault or workers' compensation insurer.

Situations Where Conditional Payment is Denied

Liability, No-Fault, or WC Claims Denied

1. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - You did not send the claim to the employer GHP first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, or WC entity, but the insurer entity did not pay the claim.

2. Medicare will deny claims when:
   - There is an employer GHP that is primary to Medicare; and
   - The employer GHP denied the claim because the GHP asserted that the liability insurer (including the self-insurer), no-fault insurer or WC entity should pay first; and
   - You sent the claim to the liability insurer (including the self-insurer), no-fault, insurer or WC entity, but the insurer entity did not pay the claim.

Denial Codes

To indicate that claims were denied by Medicare because the claim was not submitted to the appropriate primary GHP for payment, Medicare contractors will use the following codes on the remittance advice sent to you:

- Claim Adjustment Reason Code 22 - "This care may be covered by another payer per coordination of benefits" and
- Remittance Advice Remark Code MA04 -Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible."

Additional Information

You can find official instruction, CR7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R86MSP.pdf** on the CMS website.

You will find the following revised Chapters of the "*Medicare Secondary Payer Manual*," as an attachment to that CR:

Chapter 1 (Background and Overview):

- Section 10.7 (Conditional Primary Medicare Benefits),

- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements):

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and
- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements):

- Section 40.6 (Conditional Primary Medicare Benefits),
- Section 40.6.1 (Conditional Medicare Payment), and
- Section 40.6.2 (When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable).

Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN) (SE1216) (GEN)

MLN Matters® Number: SE1216 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 May 30, 2012, to remove a sentence from the last paragraph on page 2. All other information is the same.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians, providers, and suppliers who are enrolled in Medicare.

What You Need to Know

This article explains the difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). There are no policy changes in this article.

Background

New Enrollees

All providers and suppliers who provide services and bill Medicare for services provided to Medicare beneficiaries must have an NPI. Upon application to a Medicare contractor, the provider or supplier will also be issued a Provider Transaction Access Number (PTAN). While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI.

Revalidation

Section 6401(a) of the *Affordable Care Act* established a requirement for all enrolled physicians, providers, and suppliers to revalidate their enrollment information under new enrollment screening criteria.

Providers and suppliers receiving requests to revalidate their enrollment information have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the differences between the NPI and the PTAN.

National Provider Identifier (NPI)

The NPI is a **national** standard under the *Health Insurance Portability and Accountability Act* (HIPAA) Administrative Simplification provisions.

- The NPI is a unique identification number for covered health care providers.
- The NPI is issued by the National Plan and Provider Enumeration System (NPPES).

- Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions (for example, insurance claims) adopted under HIPAA.
- The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). The NPI does not carry information about healthcare providers, such as the state in which they live or their medical specialty. This reduces the chances of insurance fraud.
- Covered providers and suppliers must share their NPI with other suppliers and providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Since May 23, 2008, Medicare has required that the NPI be used in place of all legacy provider identifiers, including the Unique Physician Identification Number (UPIN), as the unique identifier for all providers, and suppliers in HIPAA standard transactions.

You should note that individual health care providers (including physicians who are sole proprietors) may obtain only one NPI for themselves (Entity Type 1 Individual). Incorporated individuals should obtain one NPI for themselves (Entity Type 1 Individual) if they are health care providers and an additional NPI(s) for their corporation(s) (Entity Type 2 Organization). Organizations that render health care or furnish health care supplies may obtain NPIs (Entity Type 2 Organization) for their organizations and their subparts (if applicable).

For more information about the NPI, visit the NPPES website at **https://nppes.cms.hhs.gov/NPPES/Welcome.do** on the CMS website.

Provider Transaction Access Number (PTAN)

A PTAN is a Medicare-only number issued to providers by Medicare contractors upon enrollment to Medicare. When a Medicare contractor approves enrollment and issues an approval letter, the letter will contain the PTAN assigned to the provider.

- The approval letter will note that the NPI must be used to bill the Medicare program and that the PTAN will be used to authenticate the provider when using Medicare contractor self-help tools such as the Interactive Voice Response (IVR) phone system, internet portal, on-line application status, etc..
- The PTAN's use should generally be limited to the provider's contacts with Medicare contractors.

Relationship of the NPI to the PTAN

The NPI and the PTAN are related to each other for Medicare purposes. A provider must have one NPI and will have one, or more, PTAN(s) related to it in the Medicare system, representing the provider's enrollment. If the provider has relationships with one or more medical groups or practices or with multiple Medicare contractors, separate PTANS are generally assigned.

Together, the NPI and PTAN identify the provider, or supplier in the Medicare program. CMS maintains both the NPI and PTAN in the Provider Enrollment Chain & Ownership System (PECOS), the master provider and supplier enrollment system.

Protect Your Information in PECOS

All providers and suppliers should carefully review their PECOS records in order to protect themselves and their practices from identity theft. PECOS should only contain active enrollment records that reflect current practice and group affiliations. You can review and update your PECOS records in the following ways:

- Use internet-based PECOS: Log on to internet-based PECOS at **https://pecos.cms.hhs.gov/pecos/login.do** on the CMS website.
- Use the Paper CMS 855 enrollment application (i.e., 855A, 855B, 855I, 855O, 855R, or 855S).
- **Note:** The Medicare contractor may not release provider specific information to anyone other than the individual provider, authorized/delegated official of the provider organization, or the contact person. The request must be submitted in writing on the provider's letterhead and signed by the individual provider, authorized/delegated official of the organization or the contact person.

The MLN fact sheet titled "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)," provides guidelines and steps you can take to protect your identity while using Internet-based PECOS. This fact sheet is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf** on the CMS website.

Additional Information

MLN Matters® Special Edition Article SE1126 titled "Further Details on the Revalidation of Provider Enrollment Information," is available at

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf on the CMS website.

"Medicare Provider-Supplier Enrollment National Educational Products," contains a list of products designed to educate Medicare Fee-For-Service (FFS) providers about important Medicare enrollment information, including how to use Internet-based PECOS to enroll in the Medicare Program and maintain their enrollment information. This resource is available at **http://www.cms.gov/MedicareProviderSupEnroll/downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf** on the CMS website.

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

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

MLN Matters® Number: MM6417 Revised
Related CR Release Date: November 1, 2011
Related CR Transmittal #: R991OTN

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

Note: *This article was revised on March 7, 2012, to reference MLN Matters® Article SE1201 (**http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf**) for important reminders on the requirements for Ordering and Referring Physicians.* ***Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record.*** *CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The "To Be Announced" implementation and effective dates in this article are the correct dates. All other information is unchanged.*

Provider Types Affected

This article is intended for physicians, non-physician practitioners, and other Part B providers and suppliers submitting claims to Carriers or Part B Medicare Administrative Contractors (MACs) for items or services that were ordered or referred. (A separate article (MM6421) discusses similar edits affecting claims from suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for items or services that were ordered or referred, and relates to CR 6421 at **http://www.cms.gov/MLNMattersArticles/downloads/MM6421.pdf** on the CMS website.

Provider Action Needed

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

Background

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

The providers who can order/refer are:

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

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

Key Points

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

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

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

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

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

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

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

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

Additional Information

You can find the official instruction, CR6417, issued to your carrier or B MAC by visiting **http://www.cms.gov/Transmittals/downloads/R991OTN.pdf** on the CMS website. If you have any questions, please contact your carrier or B MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Guidance for Correct Claims Submission When Secondary Payers Are Involved (SE1217) (GEN)

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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, physicians, and suppliers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and carriers (hereafter referred to as Medicare contractors)) for services provided to Medicare beneficiaries.

Provider Action Needed

To ensure accurate claim submissions and timely payment, providers, physicians, and other suppliers should:

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer for related services.
- Use specific and correct diagnosis codes, especially for accident related claims.

Remember: A properly filed claim prevents Medicare contractors from inappropriately denying claims and expedites the payment process.

Background

Collect full beneficiary health insurance information

It is the responsibility of all Medicare providers, physicians, and other suppliers to identify the correct primary payer by asking their patients or patients' representative questions concerning the beneficiary's Medicare Secondary Payer (MSP) status. The model hospital admissions questionnaire, published by the Centers for Medicare & Medicaid Services (CMS), may be used as a guide to collect this information from beneficiaries. This tool is available online in the "*MSP Manual*" in Chapter 3, Section 20.2.1 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf** on the CMS website. Physicians and other suppliers may also use this questionnaire to ensure MSP information is captured for use at the time of billing, so that the appropriate primary payer is billed before Medicare as required by law.

Identify and bill the correct primary payer

Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items before submitting a claim to Medicare. When another insurer is identified as the primary payer, bill that insurer first. After receiving the primary payer remittance advice, then bill Medicare as the secondary payer, if appropriate. If a patient is seen for multiple services, each service should be billed to the appropriate primary payer.

Accident Related Claims

If the beneficiary has an open MSP Liability (L), No-Fault (NF), or Workers' Compensation (WC) record, bill the L, NF, or WC insurer primary for accident-related claims first. DO NOT deny treatment.

To expedite processing and payment, the following steps should be followed:

1. Submit the accident related claim to the L, NF, or WC insurer first. If the insurer denies the claim, then bill Medicare for payment. It is important that you include all necessary MSP payment information, as found on the primary payer's remittance advice (e.g., claim adjustment reason code specifying reason for denial), on the claim sent to Medicare. If the L, NF, or WC insurer did not make payment for the accident related services, Medicare will need this information to process your claim accordingly. **If you follow these procedures, you do not need to wait 120 days to submit your claim to Medicare for payment.**

2. If the beneficiary has both a Group Health Plan (GHP) MSP coverage and L, NF, or WC coverage, you are required to submit a claim to the GHP insurer and the L, NF, or WC insurer before submitting the claim to Medicare. Once you receive the GHP remittance advice, include the GHP information along with the remittance advice information from the L, NF, and WC insurer with your claim to Medicare. If the claim is sent to Medicare without the GHP information, and there is an open GHP MSP record on file, Medicare will deny your claim.

3. In situations where there is no L, NF, or WC accident or injury, but the beneficiary has employer GHP coverage that is primary to Medicare, you must submit the claim to the GHP insurer first before submitting the claim to Medicare for secondary payment.

If you believe a claim was inappropriately denied:

- Ensure that you have submitted a correctly completed claim to the appropriate payer(s).
- Contact your Medicare contractor if you still have reason to believe a claim was denied inappropriately.
- You may need to provide information to your Medicare contractor that demonstrates why the claim was denied inappropriately. For example, a diagnosis code may have been mistakenly applied to the beneficiary's L, NF, or WC MSP record. Indicate to the Medicare contractor that the service performed is not related to the accident or injury, and Medicare should adjust and pay the claim if it is a Medicare covered and payable service.

Contact the Coordination of Benefit Contractor (COBC) at 1-800-999-1118 if a beneficiary's MSP record needs to be updated.

- The COBC collects, manages, and maintains other insurance coverage for Medicare beneficiaries.
- Providers, physicians, or other suppliers may request an update to an MSP record if they have the appropriate documentation to substantiate the change. The documentation may need to be faxed to the COBC at 734-957-9598, or the beneficiary may need to be on the line to validate the change.
- Please do not call the COBC to adjust claims or about mistaken payments. They will not be able to assist you.

Key Points

- Collect full beneficiary health insurance information upon each office visit, outpatient visit, and hospital admission.
- Identify the primary payer prior to submission of a claim, and bill the appropriate responsible payer(s) for related services.
- For multiple services, bill each responsible payer(s) separately. Do not combine unrelated services on the same claim to Medicare. Consequently, if you render treatment to a beneficiary for accident related services and non-accident related services, do not submit both sets of services on the same claim to Medicare. Send separate claims to Medicare: one claim for services related to the accident and another claim for services not related to the accident.
- Providers, physicians, and other suppliers should always use specific diagnosis codes related to the accident or injury. Doing so will promote accurate and timely payments.
- Providers should report directly to the COBC any changes to beneficiary, spouse and/or family member's employment, accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information.

Additional Information

- Specific claim-based issues or questions (including claim processing) should be addressed to the Medicare claims processing contractor at their toll-free number found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS Web site.

- If you need to report new beneficiary coverage that may be primary to Medicare or have questions regarding MSP status or claims investigation activities, contact the COBC's toll-free lines. For more information on contacting the COBC or the

Medicare Coordination of Benefits process, visit the Medicare Coordination of Benefits Web page at **http://www.cms.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation/index.html** on the CMS website.

- The Medicare Learning Network (MLN) has a Medicare Secondary Payer Fact Sheet for Provider, Physician, and Other Supplier Billing Staff (ICN 006903) at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MSP_Fact_Sheet.pdf** on the CMS website. This fact sheet is designed to provide education on the MSP provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the COBC.

Handling Misdirected Claims for Part B Items and Services (MM7629) (GEN)

MLN Matters® Number: MM7629
Related CR Release Date: May 18, 2012
Related CR Transmittal #: R2474CP
Related Change Request (CR) #: CR 7629
Effective Date: July 20, 2012
Implementation Date: July 20, 2012

Provider Types Affected

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

Provider Action Needed

Impact to You

Your misdirected claims for Part B items and services (those that you send to the wrong Medicare contractor) will be returned as unprocessable.

What You Need to Know

Change Request (CR) 7629, from which this article is taken, announces that effective July 20, 2012, your carrier or A/B MAC will return all misdirected claims as unprocessable; and your DME MAC will similarly return claims that should have been sent to a carrier or B MAC, as well as paper claims as that are sent to the wrong DME MAC.

What You Need to Do

You should make sure that claims are submitted to the correct carrier, A/B MAC, or DME MAC. See the Background section for details.

Background

A "misdirected claim" is a claim that you submit to the wrong carrier, A/B MAC, or DME MAC. As each Fee-For-Service (FFS) claims administration contractor is assigned a specific geographic and subject matter jurisdiction for claims processing, you must submit your claims to the one having the appropriate jurisdiction.

Carriers and A/B MACs previously returned as unprocessible assigned claims for Part B items and services that were sent to the wrong carrier or A/B MAC, and denied such claims that were unassigned; and DME MACs denied paper claims if sent to the wrong DME MAC.

CR7629, from which this article is taken, implements new instructions on handling misdirected claims.

Misdirected Carrier and A/B MAC Claims

With implementation of CR7629, carriers and A/B MACs will return all misdirected claims as unprocessable, **regardless of their unassigned/assigned status**. This includes: Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims that are appropriately billable to a A/B MAC or carrier, but are billed to the wrong one; and Misfiled claims for United Mine Workers of America (UMWA) and Railroad Beneficiaries (RRB) beneficiaries.

Specifically, when it receives a claim for Medicare payment for items/services that have been furnished outside of its payment jurisdiction (other than for RRB and UMWA beneficiaries), your Part A/B MAC or carrier will return it as unprocessable; using the following messages:

- Claim Adjustment Reason Code (CARC) 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remittance Advice Remark Code (RARC) N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at **www.cms.gov**.
- RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Note: *These remittance and remark code messages remain the same, and Medicare Summary Notice messages have been removed.*

Similarly, effective for claims received on and after July 20, 2012, when it receives a claim for Medicare payment for items or services that are in a DME MAC's payment jurisdiction (other than for RRB and UMWA beneficiaries), your A/B MAC or carrier will return it as unprocessable, using the same messages.

Additionally, while DME MACs will continue to follow existing procedures for misdirected beneficiary-submitted claims (CMS Form 1490S) and electronic claims; effective with implementation of CR7629, a paper claim (Form CMS -1500), sent to the wrong DME MAC will be returned as unprocessable, using the same messages.

Misdirected Railroad Beneficiaries (RRB) Beneficiary Claims

Effective July 20, 2012, when it receives a claim for an RRB beneficiary (and therefore should be processed by the RRB contractor), your carrier, A/B MAC, or DME MAC will return it as unprocessable using the following messages:

- RA - Claim Adjustment Reason Code 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remark code N105 - This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
- RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

United Mine Workers of America (UMWA) Beneficiary Claims

Effective July 20, 2012, when it receives a claim for Medicare payment that should be processed by the UMWA, your carrier, A/B MAC, or DME MAC will return it as unprocessable using the following messages:

- RA - Claim Adjustment Reason Code 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- Remark code N127 - This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.
- RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Please note that this new guidance does not apply to:

- Misdirected beneficiary-submitted claims (please refer to the "*Medicare Claims Processing Manual*," Chapter 1 (General Billing Requirements), Section 80.3.2 (Handling Incomplete or Invalid Claims) regarding the handling of such claims);
- Electronic claims for DMEPOS that are submitted to the incorrect DME MAC (misdirected DMEPOS claims are automatically routed to the appropriate DME MAC jurisdiction for processing); or
- A claim submitted to the wrong Part A MAC or Fiscal Intermediary (FI), including a Regional Home Health Intermediary (RHHI).

Additional Information

You can find the official instruction, CR7629, issued to your carrier, A/ B MAC, or DME MAC by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2474CP.pdf** on the CMS website. If you have any questions, please contact your carrier, DME MAC, or A/B MAC at their toll-free number, which may be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Information on the Centers for Medicare & Medicaid Services (CMS) Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives (SE1211) (GEN)

MLN Matters® Number: SE1211
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: 7669
Effective Date: July 1, 2012
Implementation Date: July 1, 2012

Provider Types Affected

This MLN Matters® Special Edition Article is intended for all providers and suppliers, who enroll in the Medicare program and submit Fee-For-Service (FFS) claims to Fiscal Intermediaries (FIs), carriers, A/B Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs), for services provided to Medicare beneficiaries.

What You Need to Know

This article provides you with the latest information about the Centers for Medicare & Medicaid Services (CMS) National Fraud Prevention Program (NFPP) initiative. The initiative includes additional tools to assist CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process itself. This article describes two new processes that CMS now employs as part of the provider enrollment process: (1) Automated provider screening, and (2) implementation of a new national site visit contractor that will conduct site visits to certain providers and suppliers. This NFPP is intended to protect the Medicare Program and to ensure that correct Program payment is made only for covered appropriate and reasonable services provided to Medicare beneficiaries by legitimate providers of care.

Key Information

National Fraud Prevention Program (NFPP)

The NFPP is an integral part of the CMS Fraud Prevention Initiative. The NFPP also enables CMS to proactively identify and respond to suspicious behavior, thus making the Agency more effective at fighting health care fraud than ever before. The NFPP focuses on two key program integrity gateways: provider enrollment and claims payment. By integrating these steps into one program, CMS can better ensure that it enrolls only qualified providers and pays only valid claims. CMS' comprehensive program integrity strategy is designed to stop fraudsters at every step of the process so CMS is now better able to:

- Identify and prevent bad actors from enrolling in Medicare;
- Identify and remove bad actors that are already in its programs; and
- Identify and prevent payment of fraudulent claims by responding with quick administrative action.

Automated Provider Screening: Ensuring Program Integrity at the Provider Enrollment Stage

CMS is implementing an Automated Provider Screening (APS) process that will screen providers and suppliers by automating data checks and developing methods to proactively identify fraud, waste, and abuse. APS will validate provider and supplier enrollment application information using various public and private databases as well as automatically check other referential databases. APS is expected to be fully implemented mid-2012 and it will:

- Reduce provider and supplier enrollment application processing time since there will be less manual review of the databases currently used in the verification process;
- On a continual basis, monitor the veracity and accuracy of all provider and supplier enrollment data including the status of licensure, sanctions or exclusions, and adverse legal actions;
- Assess the individual level of risk each provider and supplier presents to the Medicare program; and
- Be used by CMS and Medicare contractors (FIs, MACs, etc.) to verify, update, and act on relevant information found during the enrollment process-and on a continual enrollment basis.

APS is designed to ensure that Medicare enrolls only qualified providers and suppliers who meet and maintain compliance with its enrollment requirements.

National Site Visit Contractor: Ensuring Program Integrity at the Provider Enrollment Stage

CMS has implemented a site visit verification process using a National Site Visit Contractor (NSVC). The site visit verification process is a screening mechanism to prevent questionable providers and suppliers from enrolling in the Medicare program. The NSVC will conduct site visits for all providers and suppliers except for the Durable Medical Equipment (DMEPOS) which will continue to be conducted by the National Supplier Clearinghouse. The NSVC will verify enrollment related information during the site visit and collect specific information based on pre-defined checklists.

MSM Security Services, LLC was awarded the national site visit contract. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits. Inspectors performing the site visits will be employees of MSM, CES or HI and shall possess a photo ID and a letter of authorization issued and signed by CMS that the provider or supplier may review.

Additional Information

To learn more about the predictive analytics process, refer to MLN Matters® Special Edition Article SE1133, titled "Predictive Modeling Analysis of Medicare Claims." The article is available at **http://www.cms.gov/MLNMattersArticles/Downloads/SE1133.pdf** on the CMS website. To learn more about the CMS Fraud Prevention Initiative, visit the "Fraud Prevention Toolkit" web page at **http://www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp** on the CMS website.

July 2012 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7810) (DRU)

MLN Matters® Number: MM7810
Related CR Release Date: April 6, 2012
Related CR Transmittal #: R2440CP
Related Change Request (CR) #: CR 7810
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

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 July 2012 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 July 2, 2012, with dates of service July 1, 2012, through September 30, 2012.

What You Need to Know

Change Request (CR) 7810, from which this article is taken, instructs your Medicare contractors to download and implement the July 2012 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised April 2012, January 2012, October 2011, and July 2011 files.

What You Need to Do

You should make sure that your billing staffs are aware of the release of these July 2012 ASP Medicare Part B drug files.

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 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/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
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
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011

Additional Information

You can find the official instruction, Change Request (CR) 7810, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2440CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

July Quarterly Update for 2012 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule (MM7822) (GEN)

MLN Matters® Number: MM7822
Related CR Release Date: May 11, 2012
Related CR Transmittal #: R2467CP
Related Change Request (CR) #: CR 7822
Effective Date: January 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment MACs (DME MACs) for Durable Medical Equipment, Prosthetics Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed

This article is based on Change Request (CR) 7822 and alerts providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Note: *Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that were previously processed, will be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.*

Background

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

Key Points of CR7822

Healthcare Common Procedure Coding System (HCPCS) codes L6715 and L6880 were added to the HCPCS file effective January 1, 2012. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of service on or after January 1, 2012. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes L6715 and L6880 with dates of service on or after January 1, 2012, that have already been processed, may be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Per CR7679, the claims filling jurisdiction for the following HCPCS codes is changed from DME MAC to joint local carrier and DME MAC jurisdiction, effective January 1, 2012:

- L8511 Insert for Indwelling Tracheoesophageal Prosthesis, With or Without Valve, Replacement Only
- L8512 Gelatin Capsules or Equivalent, For Use with Tracheoesophageal Voice Prosthesis, Replacement Only, Per 10
- L8513 Cleaning Device Used with Tracheoesophageal Voice Prosthesis, Pipet, Brush, Or Equal, Replacement Only, Each
- L8514 Tracheoesophageal Puncture Dilator, Replacement Only, Each
- L8515 Gelatin Capsule, Application Device for Use with Tracheoesophageal Voice Prosthesis, Each

Additional Information

The official instruction, CR7822 issued to your FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2467CP.pdf** on the CMS website. If you have any questions, please contact your FI, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. Current and past DMEPOS Fee schedules can be viewed at **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html** on the CMS website.

Modification to CWF, FISS, MCS and VMS to Return Submitted Information When There is a CWF Name and HIC Number Mismatch (MM7260) (GEN)

MLN Matters® Number: MM7260
Related CR Release Date: April 26, 2012
Related CR Transmittal #: R2449CP
Related Change Request (CR) #: CR 7260
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

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

Provider Action Needed

If Medicare systems reject a claim when the beneficiary name does not match the Health Insurance Claim Number (HICN), your Medicare contractor will return the claim to you as unprocessable with the identifying beneficiary information from the submitted claim as follows:

- Your contractor will return to provider (RTP) Part A claims.
- Your contractor will return as unprocessable Part B claims. Your contractor will use Reason Code 140 (Patient/Insured health identification number and name do not match).

When returning these claims as unprocessable, your contractor will utilize remittance advice codes MA130 and MA61. Also, based on CR 7260, you will receive the beneficiary name information you originally submitted when the claim is returned rather than the beneficiary data associated with the potentially incorrectly entered HICN. Previously, Medicare returned the name of the beneficiary that is associated with that HICN within its files.

If an adjustment claim is received where the beneficiary's name does not match the submitted HICN, your contractor will suspend the claim and, upon their review, either correct, develop, or delete the adjustment, as appropriate.

All providers should ensure that their billing staffs are aware of these changes.

Additional Information

The official instruction, CR 7260 issued to your FI, A/B MAC, and DME/MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2449CP.pdf** on the Centers for Medicare &

Medicaid Services (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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Modifying the Timely Filing Exceptions on Retroactive Medicare Entitlement and Retroactive Medicare Entitlement Involving State Medicaid Agencies (MM7834) (GEN)

MLN Matters® Number: MM7834
Related CR Release Date: May 25, 2012
Related CR Transmittal #: R2477CP
Related Change Request (CR) #: 7834
Effective Date: August 27, 2012
Implementation Date: August 27, 2012

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 7834, which advises you that the Centers for Medicare & Medicaid Services (CMS) is revising the "*Medicare Claims Processing Manual*" to specify that, if a provider, supplier, or beneficiary is unable to provide the Medicare contractor with an official Social Security Administration (SSA) letter, the contractor must check the Common Working File (CWF) database in order to verify a beneficiary's retroactive Medicare entitlement date. Be sure that your staffs are aware of this change.

Background

The Medicare regulations at 42 Code of Federal Regulations (CFR), Section 424.44, specify the time limits for filing Part A and Part B Fee-For-Service claims. Section 424.44 also identifies certain exceptions to the claims filing time limit. If the requirements for satisfying a timely filing exception are met, an extension to file the claims may be granted.

Section 6404 of the *Affordable Care Act* reduced the maximum period for the submission of all Medicare Fee-For-Service claims to no more than 12 months, or one calendar year, after the date a service is furnished. Section 6404 also gave the Secretary of Health and Human Services the authority to create exceptions to the 12 month timely filing limit. As a result of this legislation, revisions were made to the timely filing regulations at 42 CFR, Section 424.44, and the relevant internet-only manual sections. (See Transmittal 2140/Change Request 7270, published on January 21, 2011, available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads//R2140CP.pdf**, on the CMS website.)

The "*Medicare Claims Processing Manual*" currently requires that, in order to be granted a timely filing extension, the provider, supplier, or beneficiary must furnish an official letter from the SSA to the beneficiary in order to meet one of the conditions that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service. The purpose of CR 7834 is to revise sections 70.7, 70.7.2, and 70.7.3 of the manual to specify that, if an official SSA letter to the beneficiary is not submitted, Medicare contractors must check the CWF database and may interpret the CWF data in order to verify that the beneficiary was retroactively entitled to Medicare on or before the date of the furnished service.

Consequently, CR 7834 requires the Medicare contractors to accept the SSA letter or, in the absence of such letter, to check the CWF database for a beneficiary's date of Medicare entitlement. Contractors may interpret the CWF data in order to verify retroactive Medicare entitlement that may permit a claim to be processed after the 12 month timely filing limit.

Additional Information

The official instruction, CR7834, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2477CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Negative Pressure Wound Therapy Interpretive Guidelines (SE1222) (SPE)

MLN Matters® Number: SE1222
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 suppliers who submit claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for negative pressure wound therapy services provided to Medicare beneficiaries.

What You Need to Know

This article is intended to provide interpretive guidance to Centers for Medicare & Medicaid Services (CMS) approved accrediting organizations to use in their accreditation of suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. These guidelines also apply to suppliers that are furnishing NPWT equipment to Medicare beneficiaries. SE1222 is also intended to assist the supplier in understanding their responsibilities related to this equipment in order to be in compliance with CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) quality standards.

Background

(NPWT is defined as the application of sub-atmospheric pressure to a wound to remove exudate and debris from the wound(s). NPWT is delivered to a qualified wound through an integrated system that includes:

- A Suction Pump;
- A Separate Exudate Collection Chamber; and
- Dressing Sets.

In these systems, the exudate is completely removed from the wound site to the collection chamber.

This Special Edition article, while assisting the supplier of NPWT to fulfill all Centers for Medicare & Medicaid Services (CMS) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) quality standards, does not contain a detailed discussion of all coverage and documentation requirements pertinent to this subject. Please consult the appropriate Local Coverage Determination (LCD) (or Local Coverage Article) more complete information using the Medicare Coverage Database Quick Search at **http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx** on the CMS website. Some of the more pertinent LCDs, per DME MAC Jurisdiction, are as follows:

Jurisdiction A:

L11500 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)
See **http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11500&ContrId=137&ver=35&ContrVer=1&Date=&DocID=L11500&bc=iAAAAAgAAAAA&** on the CMS website.

A35347 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article - Effective October 2011)
See **http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35347&ver=17&ContrId=137&ContrVer=1&LCDId=11500&Date=&DocID=L11500&IsPopup=y&** on the CMS website.

Jurisdiction B:

L27025 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)

See **http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=27025&ContrId=138&ver=12&ContrVer=1&Date=&DocID=L27025&bc=iAAAAAgAAAAA&** on the CMS website.

A47111 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article - Effective October 2011)
See **http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=47111&ver=8&ContrId=138&ContrVer=1&CntrctrSelected=138*1&Date=&DocID=A47111&bc=hAAAAAgAAAAA&** on the CMS website.

Jurisdiction C:

L5008 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)
See **http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=5008&ContrId=140&ver=46&ContrVer=2&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&LCntrctr=140*2&bc=AgACAAIAAAAA&** on the CMS website.

A35363 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article - Effective October 2011)
See **http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35363&ver=19&ContrId=140&ContrVer=2&CntrctrSelected=140*2&Date=&DocID=A35363&bc=hAAAAAgAAAAA&** on the CMS website.

Jurisdiction D:

L11489 (Local Coverage Determination (LCD) for Negative Pressure Wound Therapy Pumps)
See **http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=11489&ContrId=139&ver=39&ContrVer=1&Date=&DocID=L11489&bc=iAAAAAgAAAAA&** on the CMS website.

A35425 (Local Coverage Article for Negative Pressure Wound Therapy Pumps - Policy Article)
See **http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=35425&ver=17&ContrId=139&ContrVer=1&LCDId=11489&Date=&DocID=L11489&IsPopup=y&** on the CMS website.

Note: These interpretive guidelines do not address clinical aspects of NPWT, nor do they intend to assign clinical responsibilities to DMEPOS suppliers that provide the NPWT equipment to Medicare beneficiaries.

In addition to the LCDs and Articles, following are some guidelines for the CMS DMEPOS Quality Standards that CMS uses to ascertain compliance with standards:

I. Supplier Business Services Requirements

Consumer Services

CMS DMEPOS Quality Standard: Suppliers shall provide information and telephone number(s) for customer service, regular business hours, after-hours access, equipment and/or item(s) repair, and emergency coverage.

Interpretive Guidelines:

Suppliers shall demonstrate that they have provided the beneficiary/caregiver with the following information:

1. How to contact the supplier for equipment problems both during business hours and after hours through a 24/7 support function provided by the manufacturer or supplier;
2. How to access supplier staff for 24/7 technical product consultation; and
3. That they shall call their physician or 911 if a medical emergency arises.

Product Safety

CMS DMEPOS Quality Standards: Suppliers shall implement a program that promotes the safe use of equipment and item(s) and minimizes safety risks, infections, and hazards both for its staff and for beneficiaries:

Suppliers shall implement and maintain a plan for identifying, monitoring and reporting equipment and item(s) failure, repair and preventive maintenance provided to beneficiaries.

Interpretive Guideline:

- Suppliers shall demonstrate that they have ensured the equipment is cleaned between uses by different beneficiaries per the manufacturers' recommendations.

II. Supplier Product-Specific Service Requirements

Intake & Assessment

CMS DMEPOS Quality Standard: The supplier shall consult with the prescribing physician as needed to confirm the order and to recommend any necessary changes, refinements, or additional evaluations to the prescribed equipment, item(s), and/or service(s).

Interpretive Guidelines:

The supplier shall:

- Ensure the physician order contains all of the documentation requirements in the LCD, including the pump type and necessary supplies.
- If there is a home health agency involved in the patient's care, identify and document in the patient's record the home health care provider by contacting the physician.

CMS DMEPOS Quality Standard: The supplier shall review the beneficiary's record as appropriate and incorporate any pertinent information, related to the beneficiary's condition(s) which affect the provision of the DMEPOS and collaboration with the prescribing physician.

Interpretative Guidelines:

The supplier shall:

1. Confirm that the wound type or risk factors in the patient record are not among those listed in the most recent public health notification of the U.S Food and Drug Administration. Refer to the FDA's link for all of the specific clinical information at **http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm190704.htm** on the Internet.
2. Confirm that if the wound type or any of the risk factors included in the patient's record are also in the most recent guidance issued by the FDA, there is a written approval from the patient's physician that the NPWT equipment is appropriate for this patient.
3. Not supply the NPWT equipment to a beneficiary without the physician's written approval.

Delivery & Set-up

CMS DMEPOS Quality Standard: Suppliers shall deliver and set-up, or coordinate set-up with another supplier, all equipment and item(s) in a timely manner as agreed upon by the beneficiary and/or caregiver, supplier, and prescribing physician.

Interpretive Guidelines:

Suppliers shall:

1. Coordinate the delivery of the equipment with the home health care providers' home visit, if there is a Home Health Agency (HHA) involved in the patient's care.
2. Deliver the NPWT pump, dressings, and supplies prior to a beneficiary's discharge from the hospital, if the patient is being discharged from an acute care facility.

CMS DMEPOS Quality Standard: Suppliers shall provide all equipment and item(s) that are necessary to operate the equipment or item(s) and perform any further adjustments as applicable.

Interpretive Guidelines:

The supplier shall demonstrate that they have (prior to home delivery):

1. Performed quality checks on pumps, tubing, dressings, drapes, containers, and canisters per the manufacturer maintenance schedule, before delivery;
2. Confirmed that each NPWT component is operational and that equipment and supplies are available and complete prior to setup or at the time of setup;
3. Confirmed that all of the supplies are within expiration date;
4. Confirmed that the number and sizes of dressings are correct and the packaging is sterile;
5. Confirmed that the correct pump, containers/canisters, dressing, tubing is used for the specific brand of equipment according to manufacturer requirements;
6. Confirmed that clamps are available if required;
7. Confirmed that the exudate collection containers or canister are specific to the NPWT system being used;

8. Confirmed that the beneficiary has sufficient number of exudate collection containers to meet his/her wound needs based on the patient's history of drainage amount;
9. Confirmed that the alarms are setup and working properly, capable of sounding an audible alarm and/or visual alarm, dependent upon the pump type when desired pressures are not being achieved (that is, where there is a leak in the dressing seal) or the wound drainage container/canister is full or the battery is low;
10. Confirmed that the pump and the wound system (stationary or portable) are operational during use.

CMS DMEPOS Quality Standard: Suppliers shall provide, or arrange for, loaner equipment equivalent to the original equipment during any repair period except for orthotics and prosthetics.

Interpretive Guidelines:
The supplier shall demonstrate that they have:
1. Performed or arranged maintenance and repairs or replacement of the pump and supplies;
2. Given information to the beneficiary and/or caregiver(s) on how to obtain service for purchased equipment.

Training/Instruction to Beneficiary and/or Caregiver(s)
CMS DMEPOS Quality Standards: Suppliers shall provide or coordinate the provision of, appropriate information related to the set-up, features, routine use, troubleshooting, cleaning, infection control practices and maintenance of all equipment and item(s) provided.

Suppliers shall provide relevant information and/or instructions about infection control issues related to the use of all equipment and item(s) provided.

Interpretive Guidelines:
Suppliers shall demonstrate that they have provided training to the beneficiary/caregiver:
- That is specific to the system being used; and
- At a minimum it includes:
    1. Verification that new packages are not torn, damaged or opened prior to use;
    2. Operation of the pump and its settings;
    3. Written instructions that are left with the beneficiary/caregiver on the safety section of the manufacturer's manual after they have been reviewed by the supplier at a comprehension level applicable for the beneficiary/caregiver needs;
    4. Instructions on not servicing any of the equipment without calling the supplier first;
    5. What to do in case of equipment-related complications, including power failure, dislodged tube, accidental disconnection from pump and low battery;
    6. Equipment troubleshooting in case of equipment-related complications, including situations where tube replacement may be required; or alarm will not turn off or other failure of the pump or its supplies;
    7. How to contact the supplier if the physician changes settings, or the pump stops working or any review is necessary of the initial instruction;
    8. Contacting the supplier if the system shuts off;
    9. How to disconnect the system to take a shower or bath;
    10. How to disconnect the system when toileting, if the system is not portable;
    11. How to respond when the pump is turned off and the alarm sounds after a period of time;
    12. Review of the physician's order for the length of time per day that the pump has to be used;
    13. What to do if there is a sudden or rapid increase of blood under the drape, in the tubes or container;
    14. When to immediately turn off the pump;
    15. When to call the physician or other treating practitioner;
    16. Contacting the supplier if the NPWT is being discontinued or if the beneficiary is being transferred to another setting;
    17. How to arrange with the supplier for pickup or shipment of the system;
    18. The function of the clamps on the tubing both open and closed;
    19. How to attach, remove, and change the exudates collection container;
    20. Importance of infection control procedures such as good hand washing techniques when working with the pump and its supplies;
    21. How to keep the pump clean, the importance of not spilling liquids or food on the pump and wipe off spills immediately;
    22. Instruction on the frequency of canister changes. No canisters are to be re-used;

23. Disposal procedure of the tubing, dressings and canister according to local waste policy requirements.
24. The beneficiary/caregiver is given written warranty information for purchased equipment.

Follow-up

CMS DMEPOS Quality Standard: Suppliers shall provide follow-up services to the beneficiary and/or caregiver(s), consistent with the type(s) of equipment, item(s) and service(s) provided, and recommendations from the prescribing physician or healthcare team member(s).

Interpretive Guidelines:

The supplier shall have an on-going individualized service plan with a defined frequency that addresses, defines or confirms;

1. The ongoing operation and maintenance of the equipment, operation and maintenance of the equipment;
2. The frequency for scheduled/planned delivery or supply of additional supplies
3. That the beneficiary is using the equipment per the physicians order
4. The supplier picks up the equipment when it is no longer needed per the physicians orders.

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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

New Physician Specialty Code for Sleep Medicine and Sports Medicine (MM7600) (GEN)

MLN Matters® Number: MM7600 Revised
Related CR Release Date: April 27, 2012
Related CR Transmittal #: R2462CP and R209FM
Related Change Request (CR) #: 7600
Effective Date: April 1, 2012
Implementation Date: October 1, 2012

Note: This article was revised on May 9, 2012, to correct a typographical error in the second sentence of the "Provider Action Needed" Section. All other information is the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, non-physician practitioners, and suppliers who bill Medicare Carriers, Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment (DME) MACs for sleep medicine service and/or sports medicine services provided to Medicare beneficiaries.

Provider Action Needed

Effective April 2, 2012, you will need to use physician specialty code (C0) for sleep medicine services. In addition, claims submitted to DME MACs for sports medicine service should use the sports medicine specialty code of 23.

You should make sure that your billing staffs are aware of this new specialty code for sleep medicine services.

Background

Medicare physician and non-physician practitioner specialty codes describe the specific or unique types of medical services that physicians and non-physician practitioners provide. While physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I) or Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) when they enroll in the Medicare program, non-physician practitioners are assigned a Medicare specialty code when they enroll. The specialty code becomes associated with the claims submitted by physicians or non-physician practitioners. Medicare contractors also use specialty code data to develop claims processing edits.

New Specialty Code

CR 7600 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Sleep Medicine. This new physician specialty code, which will be effective April 2, 2012, is C0. PECOS and your carrier or A/B MAC will recognize and use this new code as a valid primary and/or secondary specialty code for Sleep Medicine. Also, a new specialty code is established for sports medicine and that code is 23.

Additional Information

You can find more information about the new sleep medicine specialty code by going to CR7600, located at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2462CP.pdf** on the CMS website. A related transmittal that updates the "*Medicare Financial Management Manual*" is at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R209FM.pdf** on the CMS website.

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

October 2012 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) (MM7768) (GEN)

MLN Matters® Number: MM7768
Related CR Release Date: May 18, 2012
Related CR Transmittal #: R2470CP

Related Change Request (CR) #: 7768
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers and suppliers submitting claims to Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Medicare Regional Home Health Intermediaries (RHHIs) for DMEPOS provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7768, which provides the DMEPOS October 2012 quarterly update. Change Request (CR) 7768 provides specific instructions for implementing updates to the DMEPOS Round One Rebid CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Background

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

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

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

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

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

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

Additional Information

The official instruction, CR7768, issued to your DME MAC and RHHI regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2470CP.pdf** on the CMS website. If you have any questions, please contact your DME MAC or RHHI at their toll-free number, which may be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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

Overpayment Recovery from Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (MM7744) (GEN)

MLN Matters® Number: MM7744
Related CR Release Date: April 20, 2012
Related CR Transmittal #: R208FM
Related Change Request (CR) #: CR 7744
Effective Date: May 20, 2012
Implementation Date: May 20, 2012

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers that are required to obtain and maintain a surety bond as a condition of their enrollment in the Medicare program.

Provider Action Needed

This article is based on Change Request (CR) 7744, which outlines the procedures for the Centers for Medicare & Medicaid Services (CMS) and its DME Medicare Administrative Contractors (DME MACs) to make a claim against a DMEPOS supplier's surety bond. Be certain you are aware of this information.

Background

In order to enroll in and to remain enrolled in the Medicare program, DMEPOS suppliers must obtain and maintain a surety bond in the amount of $50,000 (unless an elevated bond amount is required) under 42 Code of Federal Regulations (CFR) Section 424.57(d).

Key Points

According to 42 CFR Section 424.57(d), a surety must pay CMS, within 30 days of receiving written notice to do so, the amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible up to the full penal sum of the bond.

A surety is liable for any overpayments incurred during the term of the surety bond. This includes overpayment determinations made on or after the surety bond effective date. These overpayment determinations can relate to payments made on or after March 3, 2009.

Additional Information

The official instruction, CR7744, issued to your DME MAC regarding this change, may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R208FM.pdf** on the CMS website. If you have any questions, please contact your DME MAC at their toll-free number, which may be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. Medicare's surety bond requirements are summarized in detail in article MM6392 at **http://www.cms.gov/MLNMattersArticles/downloads/MM6392.pdf** on the CMS website.

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

MLN Matters® Number: MM7397 Revised
Related CR Release Date: April 4, 2012
Related CR Transmittal #: R2437CP
Related Change Request (CR) #: 7397
Effective Date: January 1, 2013
Implementation Date: January 1, 2013

Note: *This article was revised on April 10, 2012, to reflect the revised CR7397 issued on April 4. In this article, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.*

Provider Types Affected

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

What You Should Know

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

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

Background

Pharmacies billing drugs

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

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

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

When drugs may not be billed by pharmacies to Medicare Part B

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

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

Payment limits

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

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

Additional Information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2437CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

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

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

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

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2012 Update (MM7831) (DRU)

MLN Matters® Number: MM7831
Related CR Release Date: April 26, 2012
Related CR Transmittal #: R2450CP
Related Change Request (CR) #: CR 7831
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

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

Provider Action Needed

CR7831 announces the quarterly updating of specific Healthcare Common Procedure Coding System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2012. You should make sure that your billing staffs are aware of these HCPCS code changes.

Background

The HCPCS code set is updated on a quarterly basis. CR7831 describes the Centers for Medicare & Medicaid Services (CMS) process for updating specific HCPCS codes.

Key Points of CR7831

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will no longer be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB* Status Indicator
J1680	Human fibrinogen conc inj	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 100 MG	I
J9001	Doxorubicin hcl liposome inj	INJECTION, DOXORUBICIN HYDROCHLORIDE, ALL LIPID FORMULATIONS, 10 MG	I

* Medicare Physician Fee Schedule Data Base (MPFSDB)

Effective for claims with dates of service on or after July 1, 2012, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	Type of Service (TOS) Code	MPFSDB Status Indicator
Q2034	Agriflu vaccine	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, FOR INTRAMUSCULAR USE (AGRIFLU)	V	X
Q2045	Human fibrinogen conc inj	INJECTION, HUMAN FIBRINOGEN CONCENTRATE, 1 MG	1,9	E
Q2046	Aflibercept injection	INJECTION, AFLIBERCEPT, 1 MG	1,9	E
Q2047	Peginesatide injection	INJECTION, PEGINESATIDE, 0.1 MG (FOR ESRD ON DIALYSIS)	L	E
Q2048	Doxil injection	INJECTION, DOXORUBICIN HYDROCHLORIDE, LIPOSOMAL, DOXIL, 10 MG	1,9	E
Q2049	Imported Lipodox inj	INJECTION, DOXORUBICIN HYDROCHLORIDE, LIPOSOMAL, IMPORTED LIPODOX, 10 MG	1,9	E

Additional Information

The official instruction, CR 7831, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2450CP.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Questionable Billing By Suppliers of Lower Limb Prostheses (SE1213) (O&P)

MLN Matters® Number: SE1213
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 who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What You Need to Know

This article highlights the August 2011 report from the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) study titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It also discusses Medicare policy regarding the coverage of lower limb prostheses under its Part B Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit.

The study was designed to meet the following objectives:

1. Identify payments for lower limb prostheses in 2009 that did not meet certain Medicare requirements;
2. Identify Medicare payments for lower limb prostheses in 2009 for beneficiaries with no claims from their referring physicians;
3. Identify suppliers of lower limb prostheses that had questionable billing in 2009; and
4. Describe the program safeguards in place in 2009 and the first half of 2010 to prevent inappropriate payments for lower limb prostheses.

Background

Between 2005 and 2009, Medicare spending for lower prostheses increased 27 percent, from $517 million to $655 million. The number of Medicare beneficiaries receiving lower limb prostheses decreased by 2.5 percent, from almost 76,000 to about 74,000.

Medicare policy requires that a supplier have an order from the referring physician before providing prostheses to the beneficiary. Upon receipt of the referring physician's order, the supplier can move forward with the prostheses fitting for the beneficiary with the applicable prostheses. Medicare policy also requires that suppliers follow local coverage determination policies. These policies provide guidelines for determining the beneficiary's potential functional level and specify how suppliers must submit claims for certain types and combinations of prostheses.

The study completed by the OIG was based on an analysis of Medicare Part B claims for lower limb prostheses from 2009 and Part A and Part B claims from 2004 to 2009 for beneficiaries who received lower limb prostheses in 2009. OIG staff also completed interviews with the four DME Medicare Administrative Contractors (MACs), three Zone Program Integrity Contractors (ZPICs), and two DME Program Safeguard Contractors (PSCs). The OIG considered a paid claim did not meet the requirements if the supplier:

- Did not indicate whether the prosthesis was for the right or left limb;
- Billed for a prosthesis for both limbs on the same date using two claims;
- Did not meet potential functional level requirements;
- Billed for a higher number of units of a prosthesis than allowed on a claim;
- Billed for combinations of prostheses that were not allowed; or
- Billed for prostheses that were not covered.

Claims data was an additional component of the OIG's analysis to determine the number of claims for beneficiaries with no claims from their referring physicians during the last 5 years and the Medicare payments for these claims. The following elements were analyzed to identify suppliers that had questionable billing:

- Suppliers that had at least 10 beneficiaries, and
- Suppliers that were paid at least $100,000 for lower limb prostheses in 2009.

This sample included 1,632 of the 4,575 Medicare suppliers who had a paid claim for lower limb prostheses in 2009, which accounted for 92 percent of the $655 million who billed for lower limb prostheses.

Findings

In 2009, the study found that:

1. In 2009, Medicare inappropriately paid $43 million for lower limb prostheses that did not meet certain requirements. These payments could have been prevented by using claims processing edits.
2. Medicare paid an additional $61 million for beneficiaries with no claims from their referring physicians.
3. In 2009, 267 suppliers of lower limb prostheses had questionable billing. Approximately 136 suppliers frequently submitted claims that did not meet certain Medicare requirements or were for beneficiaries with no claims from their referring physicians. An additional 131 suppliers had other questionable billing. This included billing for a high percentage of beneficiaries with no history of an amputation or missing limb or a high percentage of beneficiaries with unusual combinations of prostheses.
4. Medicare contractors conducted varying degrees of program safeguard activities related to lower limb prostheses.
    - The four DME MACs had varying claims processing edits in place, but none had edits for all requirements.
    - None of the DME MACs conducted medical reviews, and not all had conducted data analyses or provided education related to lower limb prostheses.
    - All ZPICs and DME PSCs conducted data analyses and opened investigations related to lower limb prostheses.

Recommendations

The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. In response to the first recommendation, to implement additional claims processing edits, CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

In response to the second recommendation, to strengthen monitoring of billing for lower limb prostheses, CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

In response to the third recommendation, to implement requirements for a face-to-face encounter to establish a beneficiary's need for prostheses, CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

In response to the fourth recommendation, to revise the local coverage determination, CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

In response to the fifth recommendation, to enhance screening for currently enrolled suppliers of lower limb prostheses, CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

In response to the sixth recommendation, to take appropriate action on the suppliers with questionable billing, CMS concurred and stated it would share the information with the DME MACs and the Recovery Audit Contractors. Recovery Audit Contractors review Medicare claims on a post payment basis to identify inappropriate payments.

The following section reviews Medicare policy for coverage of lower limb prostheses.

Key Points

Medicare Requirements for Lower Limb Prostheses

General Information

Provisions of the *Social Security Act* (the Act) govern Medicare payment for all items or services, including lower limb prostheses. The Act states that Medicare will cover only services and items considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

In addition, Medicare requires that a supplier have an order from a physician before providing prostheses to the beneficiary. This physician is known as the referring physician. Upon receiving the order, the supplier consults with the referring physician, as needed, to confirm the order and recommend any necessary changes and evaluates the beneficiary. The supplier fits the beneficiary with the most appropriate prostheses. The supplier then determines the group of codes that best describes the prostheses provided, choosing from 178 Healthcare Common Procedure Coding System (HCPCS) codes that are specific to lower limb prostheses.

Further, local coverage determination policies provide additional Medicare requirements for lower limb prostheses. These policies, consistent with policies for other DMEPOS, are identical across the country. The local coverage determination specifies how suppliers must submit claims for certain types and combinations of prostheses. In particular, it states that each claim must include a modifier to indicate whether the prosthesis is for the right or left limb. When a supplier provides prosthesis for each limb on the same date, the supplier must submit only one claim and include both the right and left modifiers on the claim.

The local coverage determination also has guidelines for determining the beneficiary's potential functional level. Specifically, it states that a beneficiary is placed at one of five potential functional levels based on the reasonable expectations of the supplier and the referring physician. When determining the potential functional level, suppliers must take into account the beneficiary's history, current condition, and desire to walk. The supplier then uses a modifier on the claim to indicate the beneficiary's potential functional level (K0 to K4). Prostheses are not considered medically necessary if the beneficiary has the lowest potential functional level (K0), which indicates that he or she does not have the ability or the potential to walk. In addition, for some prostheses, the local coverage determination specifies the minimum potential functional level that the beneficiary must have for the prosthesis to be considered medically necessary.

Further, the local coverage determination limits the number of certain prostheses that can be billed on a claim. If the number of units of these prostheses exceeds the limit, the additional items will be denied as not medically necessary. The local coverage determination also considers certain combinations of prostheses to be medically unnecessary. For example, certain sockets are not allowed for use with temporary base prostheses. Finally, the local coverage determination states that HCPCS L5990, a specific type of foot addition, will be denied as not medically necessary.

In addition, CMS recently established new screening procedures for provider enrollment. For example, screening may include licensure and criminal background checks. CMS created three levels of screening - limited, moderate, and high - based on the risk of fraud, waste, and abuse. New DMEPOS suppliers were placed at the high risk level, while currently-enrolled DMEPOS suppliers were placed at the moderate risk level.

Lastly, recent legislation established a face-to-face encounter requirement for certain DMEPOS. For specified DMEPOS that require a written order prior to delivery, the referring physician must document that a physician, physician assistant, nurse practitioner, or clinical nurse specialist has had a face-to-face encounter with the beneficiary before writing the order for the item.

Note: *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. You may want to review MLN Matters® Article SE1201 at* **http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf** *for important reminders on the requirements for Ordering and Referring Physicians.*

Additional Information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at **http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf** on the OIG website.

Redesigned Medicare Summary Notices (SE1218) (GEN)

MLN Matters® Number: SE1218
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation Date: NA

Provider Types Affected

This MLN Matters® Special Edition Article is informational in nature and is intended for all providers who provide Medicare-covered services in the Medicare Fee-For-Service (FFS) program.

Background

The Centers for Medicare & Medicaid Services (CMS) has announced the redesign of the statement that informs Medicare beneficiaries about their claims for Medicare benefits.

What You Need to Know

CMS will make the redesigned statement, known as the Medicare Summary Notice (MSN), available online. Starting in 2013, CMS will mail the MSN to beneficiaries quarterly.

The MSN redesign is part of a new initiative, "Your Medicare Information: Clearer, Simpler, At Your Fingertips". This initiative aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand.

CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for people who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

Features of the Redesigned MSN

The redesign of the MSN includes several features that are not available in the current MSN, including:

- A clear notice on how to check the form for important facts and potential fraud;
- An easy-to-understand snapshot of:
  - The beneficiary's deductible status,
  - A list of the providers they saw, and
  - Whether Medicare approved their claims;
- Clearer language, including consumer-friendly descriptions for medical procedures;
- Definitions of all the column headers present in the form;
- Larger fonts to make it easier to read; and
- Information on preventive services available to Medicare beneficiaries.

For More Information

The redesigned MSN is available on **www.mymedicare.gov**, which is Medicare's secure online service for personalized information regarding Medicare benefits and services. To see a side-by-side comparison of the former and redesigned MSNs, please visit **http://www.cms.gov/apps/files/msn_changes.pdf** on the CMS website. To view the CMS press release on the MSN redesign, please visit: **http://www.CMS.gov/apps/media/press/release.asp?Counter=4298** on the CMS website.

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

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

MLN Matters® Number: MM7499 Revised
Related CR Release Date: May 10, 2012
Related CR Transmittal #: R1088OTN

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

Note: *This article was revised on May 14, 2012, to reflect a revised CR7499 issued on May 10. The article was revised to show (above) the correct implementation date of October 1, 2012 for claims submitted to DME MACs. In addition, the transmittal number, release date, and the Web address for accessing CR7499 were revised. All other information is the same.*

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

Additional Information

The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1088OTN.pdf** on the CMS website. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Revision of Medicare Summary Notice (MSN) for Non-Competitive Bid Claims (MM7729) (GEN)

MLN Matters® Number: MM7729
Related CR Release Date: March 9, 2012
Related CR Transmittal #: R1056OTN
Related Change Request (CR) #: CR 7729
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries who reside in Non-Competitive Bidding Areas.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 7729 which corrects Medicare Summary Notice (MSN) message (MSN 16.07) incorrectly displaying on MSNs for non-competitive bid claims.

What You Need to Know

CR7729 instructs your Medicare contractor to use MSN message 16.71 (as follows) for beneficiary submitted **non-National Competitive Bidding (non-NCB) related claims**: Your provider must complete and submit your claim. In addition, CR7729 instructs your Medicare contractor to use MSN 16.07 (as follows) for beneficiary submitted **NCB- related claims** (per CR7066): Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program.

What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Medicare Summary Notices (MSN) is the primary vehicle by which beneficiaries are notified of decisions on their claims for Medicare benefits. Medicare contractors mail a single MSN at the end of the month to each beneficiary for whom a claim was processed during the month to inform the beneficiary of the disposition of their claims. The contractors issue No-Pay MSNs on a quarterly/90 day mailing cycle, and MSNs with checks (to the beneficiary) are mailed out as processed.

The Centers for Medicare & Medicaid Services (CMS) learned that a Durable Medical Equipment Prosthetic, Orthotic and Supplies (DMEPOS) National Competitive Bidding (NCB) MSN message, (MSN 16.07), is incorrectly displaying on MSNs for non-competitive bid claims.

MSN 16.07 currently reads "Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program". This language was established for beneficiary-submitted NCB claims, effective with the implementation of CR7066 (Transmittal 777, September 24, 2010, "Durable Medical Equipment (DME) National Competitive Bidding (NCB) Implementation - Phase 11E: Remittance Advice (RA) and Medicare Summary Notice (MSN) Messages for Round One." You can review CR7066 at **http://www.cms.gov/transmittals/downloads/R777OTN.pdf** on the CMS website. Prior to the implementation of CR7066, MSN 16.07 read, "Your provider must complete and submit your claim."

In order to resolve the issue of the incorrect MSN being displayed, CR7729 instructs your Medicare contractor to:

- Use MSN message 16.71 for beneficiary submitted non-NCB related claims: Your provider must complete and submit your claim.
- Use MSN 16.07 for beneficiary submitted NCB- related claims (per CR7066). Your provider must complete and submit your claim in accordance with DMEPOS Competitive Bidding Program.

Additional Information

The official instruction, CR7729, issued to your DME MACs regarding this change may be viewed at **www.cms.gov/transmittals/downloads/R1056OTN.pdf** on the CMS website. If you have any questions, please contact your DME MACs at their toll-free number, which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

Use of Revised Remittance Advice Remark Code (RARC) N103 When Denying Services Furnished to Federally Incarcerated Beneficiaries (MM7678) (GEN)

MLN Matters® Number: MM7678 Revised
Related CR Release Date: March 7, 2012
Related CR Transmittal #: R1054OTN
Related Change Request (CR) #: 7678
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Note: *This article was revised on March 9, 2012 to reflect the revised CR7678 issued on March 7. In this article, the CR release date, transmittal number, and the Web address for accessing CR7678 were revised. All other information is the same.*

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries who are incarcerated in a Federal facility.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 7678 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending Remittance Advice Remark Code (RARC) N103 to include language that further explains the newly modified RARC N103—denying claims for services to federally incarcerated beneficiaries.

What You Need to Know

CR7678 is limited to providers billing for services for beneficiaries while they are in Federal, State, or local custody and the goal of this CR7678 is to be more specific in explaining the accompanying adjustment.

What You Need to Do

See the Background, Key Points, and Additional Information Sections of this article for details regarding these changes.

Background

The following exclusions presumptively apply to individuals who are incarcerated in a Federal facility under Federal authority:

- According to Federal regulations at 42 Code of Federal Regulations (CFR) Section 411.4 Medicare does not pay for services furnished to a beneficiary who has no legal obligation to pay for the service and no other person or organization has a legal obligation to provide or pay for the service;
- Under 42 CFR 411.6, Medicare does not pay for services furnished by a federal provider of services or by a federal agency; and
- Under 42 CFR 411.8, Medicare does not pay for services that are paid for directly or indirectly by a governmental entity.

Key Points

When denying claims for services furnished to federally incarcerated Medicare beneficiaries, the newly modified RARC N103 will be used (in addition to remittance advice language already in use) and it reads as follows:

> "Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt."

Additional Information

The official instruction, CR7678, issued to your Medicare contractors (FIs, A/B MACs, DME MACs, and carriers) regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R1054OTN.pdf** on the CMS website. If you have any

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

CMS News Flash (GEN)

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

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

REVISED products from the Medicare Learning Network® (MLN)

- "*CMS Website Wheel*," Educational Tool, ICN 006212, Hard Copy
- "*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards*", Booklet, ICN 905709, Downloadable and Hard Copy

Medicare is denying an increasing number of claims, because providers are not identifying, nor sending claims to, the correct primary payer prior to claims submission. Medicare would like to remind providers, physicians, and suppliers that they have the responsibility to bill correctly and to ensure claims are submitted to the appropriate primary payer. Please refer to the "*Medicare Secondary Payer (MSP) Manual*," Chapters 1, 3, and 5 and MLN Matters® Article SE1217 for additional guidance.

Over the last year, the Centers for Medicare & Medicaid Services (CMS) has listened to your feedback about the Medicare online enrollment system, Provider Enrollment, Chain, and Ownership System (PECOS). As a result, we've made upgrades in order to reduce data entry time and increase access to information. Providers and staff using internet-based PECOS will now be able to digitally sign and certify your application and to see more information such as whether a request for revalidation has been sent to you by your Medicare contractor. You will be able to switch from Topic View to Fast Track View to review all of your enrollment information in a single screen. Overall, the system will be easier for you to use. Learn more about PECOS at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html** and be on the look-out for more enhancements in the coming months!

It's Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) also recommends that patients, healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. **Get the Flu Vaccine - Not the Flu.** Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related provider resources, visit 2011-2012 Provider Seasonal Flu Resources and Immunizations. For the 2011-2012 seasonal flu vaccine payment limits, visit **http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

Has Medicare sent you a notice to revalidate your enrollment? If you are not sure, you can find lists of providers sent notices to revalidate their Medicare enrollment by scrolling to the "Downloads" section at **http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp** on the Centers for Medicare & Medicaid Services

(CMS) website. That site currently contains links to lists of providers sent notices from September, 2011 through January, 2012. Information on revalidation letters sent in February will be posted in late March. For ease of reference, the lists are in order by National Provider Identifier and the date the notice was sent.

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

The Centers for Medicare & Medicaid Services is pleased to announce the **scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set**. These changes have been posted to the HCPCS website at **http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html** on the CMS website. Changes are effective on the date indicated on the update.

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services **provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT)**. Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official. For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article SE1126, "*Further Details on the Revalidation of Provider Enrollment Information.*"

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:

- There are no updates to the 2nd Quarter 2012 Jurisdiction A DME MAC Fee Schedule
- 2nd Quarter 2012 Average Sales Price Medicare Part B Drug Pricing File
- 2nd Quarter 2012 Oral Anticancer Drug Fees

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

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

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

DME MAC Jurisdiction A Local Coverage Determinations

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**

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

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

Ankle-Foot/Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 07/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Coverage of concentric adjustable torsion joints (Effective 3/13/2012)

DOCUMENTATION REQUIREMENTS:

Added: Documentation of custom-fabricated items

POLICY ARTICLE

Revision Effective Date: 07/01/2012

CODING GUIDELINES:

Added: Coding guidelines for L1906

Revised: Coding guidelines for concentric adjustable torsion joints (Effective 3/13/2012)

Added: Coding verification for codes L1906, L1930, L1932, L1940, L1960, L1970 and L1971

Added: Repair and replacement guidelines

External Breast Prosthesis

LCD

Revision Effective Date: 06/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:

Revised: Order requirement language to specify a "detailed written order"

Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)

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*)

Revised: Prescription requirements

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

POLICY ARTICLE

Revision Effective Date: 06/01/2012

NON-MEDICAL NECESSITY AND COVERAGE AND PAYMENT RULES:

Revised: Preamble language

CODING GUIDELINES

Revised: Descriptions for L8000, L8001 & L8002

Glucose Monitors

LCD

Revision Effective Date: 07/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Basic coverage criteria for glucose monitor and supplies
Revised: Coverage criteria for high utilization
Revised: Order requirements language to specify a "detailed written order"
Changed: Word "Patient" to "Beneficiary"
Clarified: Coverage of laser lancing devices and lens shield cartridges

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*)

Revised: Prescription requirements
Added: Medical Record Information
Added: Documentation of beneficiary training
Added: Documentation requirements for high utilization

Knee Orthoses

LCD

Revision Effective Date: 07/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Order requirements language to specify a "detailed written order"
Added: Coverage for concentric adjustable torsion joints (Effective 3/13/2012)
Added: Code L2755 to Addition Codes - Eligible for Separate Payment table
Added: ICD-9 codes 733.81-733.82 and 905.4 for L1830, L1832, L1843, L1845 to coverage table per request for reconsideration.
Changed: Word "Patient" to "Beneficiary"

HCPCS CODES AND MODIFIERS

Added: Code L2755

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-9 codes 733.81-733.82 and 905.4 for L1830, L1832, L1834, L1843, L1844, L1845, L1846 per request for reconsideration.

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

POLICY ARTICLE

Revision Effective Date: 07/01/2012

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Reference to LCD for R & N requirements
Changed: Patient to Beneficiary

CODING GUIDELINES:

Added: Definition of code L2755
Added: Coding guidelines for concentric adjustable torsion joints (Effective 3/13/2012)

Mechanical In-exsufflation Devices

LCD

Revision Effective Date: 05/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Prescription requirement

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-9 359.71

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*)

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

Manual Wheelchair Bases

LCD

Revision Effective Date: 05/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Order requirement language to specify a "detailed written order"

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*)

Revised: Prescription requirements

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

Removed: paragraph about individual consideration and changed "patient" to "beneficiary".

Added: Clarified Home Assessment documentation

POLICY ARTICLE

Revision Effective Date: 05/01/2012

CODING GUIDELINES:

Added general language, PDAC verification and E1161 to language about wheel design.

Changed: DMERC to DME MAC

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

Concentric Adjustable Torsion Joints - Correct Coding (O&P)

Based on a benefit category determination from the Centers for Medicare & Medicaid Services (CMS), the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) are revising the Knee Orthosis and Ankle-Foot/Knee-Ankle-Foot Orthosis policy articles. The revision includes information about the proper coding of concentric adjustable torsion-style mechanisms incorporated into orthotics.

The distinction in coding relates to the indicated use of the joint and the beneficiary's medical condition(s). Concentric adjustable torsion-style joints used solely to provide an assistive function for joint motion must be coded L2999 or L3999. When concentric adjustable torsion-style joints are used for any condition other than to provide an assistive function for joint motion, they must be coded as durable medical equipment using the following codes:

E1800 - Dynamic adjustable elbow extension/flexion device
E1802 - Dynamic adjustable forearm pronation/supination device
E1805 - Dynamic adjustable wrist extension/flexion device
E1810 - Dynamic adjustable knee extension/flexion device
E1815 - Dynamic adjustable ankle extension/flexion device

The effective date of the local coverage determination (LCD) and related Policy Article revision for the concentric adjustable torsion-style mechanisms will be for claims with dates of service on or after March 13, 2012. The remainder of the LCD and related Policy Article revisions will be effective for dates of service on or after July 1, 2012.

Suppliers of these products are strongly encouraged to read the AFO/KAFO and KO local coverage determinations and related policy articles for additional information on coverage, coding and documentation.

Correct Billing for Upper Limb Prosthesis with L6895 instead of L7499 (O&P)

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs), have discovered suppliers billing healthcare common procedure coding system, HCPCS L7499, [upper extremity prosthesis, not otherwise specified] for upper limb prosthetic cosmetic features such as; coloring, veins, hair, etc. Suppliers should be billing L6895 [addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated].

HCPCS L6895 is the appropriate code to bill for a prosthetic cosmetic glove including matching color, hair, skin, and wrinkles. Suppliers should **NOT** bill using HCPCS L7499 for the cost of the additional cosmetic features. The long narrative description for the L6895 indicates "any material" and therefore includes all of these cosmetic features.

If suppliers believe the addition of these features changes the narrative description, they are encouraged to seek a new HCPCS code through the CMS' Alpha Numeric Workgroup. Located on the CMS web site:
http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html

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Glucose Monitors - Policy Revision Summary (SPE)

Effective for dates of service on or after 07/01/2012, the local coverage determination (LCD) for home blood glucose monitors and supplies is being revised. The changes primarily reflect standardization of language and simplification of coverage criteria. Highlights of the changes include:

Indications and Limitations of Coverage and/or Medical Necessity Section

- Consolidated basic coverage criteria into two criteria
- Revised the training requirement (Basic criterion 2)
- Clarified that utilization parameters are based on insulin use status
- Standardized strip utilization parameters based on three (3) month billing timeframe,
- Clarified the coverage requirements for usual utilization and high utilization of testing strips
- Moved treating physician documentation of strip utilization from Indications and Limitations of Coverage and/or Medical Necessity (ILCMN) Section to Documentation Section

Documentation Requirements Section

- Added standard documentation requirements, including orders, refill documentation, continued use, continued need and proof of delivery
- Clarified that on the Detailed Written Order (DWO), listing the frequency of use is only required for strips and lancets

Policy-Specific Documentation Requirements Section

- Changed section name from "Miscellaneous Information" to "Policy-Specific Information"
- Moved from ILCMN Section requirements for documenting medical necessity for high utilization beneficiaries
- Provided additional details for documentation of in-person visit with the treating physician

Note that the requirement for the beneficiary to maintain a log of testing results has been removed from the LCD. Documentation of continued medical need for usual utilization beneficiaries is addressed in the "Continued Need" section. Documentation of continued medical need for high utilization beneficiaries is addressed in the "Policy-Specific Information" section.

This article only summarizes the changes in the LCD. Suppliers are strongly encouraged to read the entire LCD and related policy article for additional information on the coverage, coding and documentation of blood glucose monitors, supplies and related accessories.

Positive Airway Pressure (PAP) Devices - Supplier Frequently Asked Questions - REVISED - May 2012 (SPE)

Question 20 has been updated.

Ordering/Treating Physician Issues

Q1: The LCD uses the term "treating physician" in various places. What is the definition of a treating physician?

A1: Medicare statute defines treating physician as one "…who furnishes a consultation or treats the beneficiary for a specific medical problem and who uses the [diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests] results in the management of the beneficiary's specific medical problem." In a scenario where the beneficiary visits their primary care provider (PCP) who then refers the beneficiary to a sleep specialist for a polysomnogram and subsequent treatment with PAP and follow-up, both the PCP and the sleep specialist would be considered a "treating physician" within the context of Medicare regulations. Both physicians are engaged in diagnosing and treating the beneficiary for sleep disordered breathing. This scenario is quite common in medical practice where the primary medical care for the patient is rendered by the PCP and subspecialty physician consultation is engaged for specific diagnostic and/or therapeutic treatment outside the scope of the PCP's area of medical expertise.

Q2: Are nurse practitioners, clinical nurse specialists and physician assistants allowed to conduct the initial clinical evaluation and/or follow-up evaluation since the LCD states this must be done by the treating physician?

A2: Yes. Medicare regulations provide for the use of nurse practitioners, clinical nurse specialists and physician assistants in the care of Medicare beneficiaries. The *Social Security Act* §1861(s) addresses the provision of Medical and Other Services as follows:

Physician Assistants: (K)(i) services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Nurse Practitioners and Clinical Nurse Specialists: (K)(ii) services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Q3: Can a registered nurse (RN) conduct the follow-up evaluation?

A3: No, the treating physician must be directly involved in the follow-up evaluation.

Q4: The policy states that the data that the physician evaluates must be for a period of 30 consecutive days. The policy is silent on a time frame in which the physician must see the patient in relationship to the data.

A4: The physician may see the patient and conduct the follow-up evaluation between the 31st and 91st day. Continued coverage of a PAP device requires that a determination be made by the treating physician that the patient is benefiting from the use of the selected device as evidenced by a face-to-face clinical follow-up evaluation and adherence to therapy. While the documentation of adherence may occur following the treating physician's follow-up evaluation, the adherence report must be provided to the treating physician for inclusion in the patient's medical record in order to fulfill the requirement to assess therapy benefit. Consider the following example:

- 11/01/08 Patient set up with a PAP device
- 12/05/08 Face-to-face re-evaluation indicates subjective improvement, but objective data is not available
- 01/30/09 Supplier obtains data demonstrating adherent use; faxes to MD for review
- 02/01/09 Add KX modifier to fourth month's claim

Q5: Does the treating physician who does the initial face-to-face examination have to write the order for the PAP therapy or can it be ordered by the interpreting physician from the sleep lab?

A5: The treating physician that does the initial face to face exam does not have to be the same physician that orders the CPAP.

Q6: Is there a time limit from initial face-to-face evaluation to the sleep study?

A6: No time limit is specified in the policy; however, one would anticipate that these two events occur reasonably close together in time, typically within 3 months.

Adherence Monitoring

Q7: Help us understand the term "visual inspection" as it relates to adherence monitoring. What does this mean and how can it be documented?

A7: The LCD was revised to include allowance for visual inspection based on comments that not all suppliers use devices that allow downloading of adherence information. Visual inspection means determining adherence by looking at information on the PAP device's display screen and documenting the values in a written report. As noted in a prior FAQ, the supplier may contact the beneficiary via telephone and ask them to read values from their device (i.e., phone-in compliance) or the supplier or physician may read the values during a home/office visit. The values must document that the patient is using the device for 4 or more hours per night for 70% of the nights in a consecutive 30-day period.

Q8: Can we report hours used, for example with information from a device with an hour meter, and meet the requirement for documenting adherence? For example, "Spoke to patient and she states that as of 12/01/08, there are a total of 650 hours on her CPAP machine. She states that she uses the CPAP every night and it is very beneficial. On 11/01/08, the beginning reading was 500 hours. This calculates to 5 hours per night for 30 days."

A8: No. Devices that simply report "device on" time or "blower on" time will not provide enough information to determine that the PAP device was used $\geq$ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

Q9: Several manufacturers have devices that report "sessions" of use. Are these types of devices acceptable to meet the LCD requirement for adherence?

A9: Possibly, depending on the definition of "session" which can vary based on the manufacturer or the session definition if a user-defined option. For example, consider a device that measures a "session" as use greater than X hours and also reports number of days used. Assuming that a session was set up to measure use $\geq$ 4 hours, one could use the number of session in conjunction with total days of use over a 30 day period and determine whether or not the patient met the adherence requirement.

Q10: We use devices from a manufacturer that reports adherence information on a rolling 30 day basis. Information is displayed in a window on the device; however, adherence may vary depending on which 30 day period is examined. How can we use this device and still meet the adherence requirement?

A10: Devices that report information on a rolling 30 day interval can be problematic if using visual inspection as the reporting method. One solution is to engage the beneficiary in their care and emphasize the importance of monitoring their therapy, including the potential loss of Medicare reimbursement for their PAP device due to failure to meet the adherence requirements. In the scenario with this specific piece of equipment, the supplier should instruct the beneficiary to monitor their device after the initial 30 days of use and report back to the supplier the point at which they meet the adherence metric.

Note that most devices that allow one to potentially determine adherence through visual inspection are designed to report adherence information in much greater detail via download. Suppliers are strongly encouraged to discuss the capabilities of devices being considered for purchase with each manufacturer to determine the capacity for reporting adherence as defined in the LCD.

Q11: Must suppliers continue to document adherence as defined in the LCD after the initial 3 month period?

A11: No. Following the initial 3 month trial and documentation of use $\geq$ 4 hrs. per night on 70% of nights in a 30 consecutive day period, suppliers should document continued use of the device. This may be accomplished via documentation of attestation by the beneficiary.

Q12: The PAP LCD states "Adherence to therapy is defined as use of PAP $\geq$ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage." Can you please clarify whether the $\geq$ 4 hours per night is continuous use or cumulative use in a 24 hour period? Would a patient who uses the device for 4 hours a night, but has a break in usage of 45 minutes still satisfy the requirements of the LCD?

A12: The $\geq$ 4 hours per night is based on continuous use, with allowances for short breaks (e.g., toileting).

Q13: A patient was placed on PAP therapy and during the course of their 12 week trial period they were hospitalized for two weeks. How does this impact the requirement for adherence monitoring and timing of the face-to-face follow-up evaluation?

A13: The 12 week trial period applies to PAP use in the home setting. If a patient is admitted to an inpatient hospital or skilled nursing facility (SNF), the trial period is suspended. The trial period, including the requirement for adherence monitoring and the timing of the face-to-face re-evaluation (i.e., between the 31st and 91st day) resumes when the patient returns home.

Q14: Can continued coverage of PAP therapy be extended to patients who come close to meeting the adherence metric requirements but don't quite achieve all of them in the 90 day timeframe?

A14: No. All of the requirements must be met within the 90 day time frame. CMS' national coverage determination contained specific language that benefit from PAP therapy must be demonstrated in the first 12 weeks in order to provide continued coverage beyond that time. Compliance is a major issue with CPAP; failure of therapy is often related to mask fit, humidification, ramp time, etc. Most of these issues arise in the first few days of treatment and must be aggressively addressed by the supplier and/or treating physician. Even if that takes 4-6 weeks there is still adequate time to achieve the liberal local coverage determination metric of $\geq$ 4 hours per night on 70% of the nights in a 30 day period.

Reimbursement Issues

Q15: A patient received a CPAP device paid for by fee for service (FFS) Medicare in 1998 and now needs to replace their device. Do they have to get a face-to-face evaluation, a new sleep study and meet the other requirements in the new LCD?

A15: According to the LCD:

If a PAP device is replaced during the 5 year reasonable useful lifetime (RUL) because of loss, theft, or irreparable damage due to a specific incident, there is no requirement for a new clinical evaluation, sleep test, or trial period.

If a PAP device is replaced following the 5 year RUL, there must be a face-to-face evaluation by their treating physician that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

Q16: A patient was diagnosed with obstructive sleep apnea and received a PAP device paid for by private insurance. The patient is now enrolled in FFS Medicare and needs a replacement PAP device and/or accessories. What is required for coverage?

A16: For beneficiaries who received a PAP device prior to enrollment in FFS Medicare and are now seeking Medicare coverage of either a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test - There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare, 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,
2. 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:
    a. The beneficiary has a diagnosis of obstructive sleep apnea; and,
    b. The beneficiary continues to use the PAP device.

If either criteria 1 or 2 above are not met, the claim will be denied as not medically necessary. The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of the beneficiary's enrollment in FFS Medicare.

Q17: DME company ABC conducts home sleep tests and then refers patients to DME company XYZ for PAP therapy after the physician makes the diagnosis of obstructive sleep apnea. Since the two companies are not related and DME company XYZ did not conduct the home sleep test, is DME company XYZ allowed to dispense the PAP device based on this test?

A17: No, a DME supplier is not a qualified provider of laboratory services; therefore, this is not a valid test for Medicare purposes. According to the PAP LCD, "No aspect of an HST [home sleep test], including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests."

Q18: **If a patient is put on a RAD device with less than 30 day left in the initial 91 day period, the LCD indicates that the patient will be given to 120 days after the initiation of PAP therapy to document adherence. If the patient had a face to face exam in the 31 to 91 day period while on a CPAP device, must they have another face to face exam after they are on RAD? Certainly if they did not have a face to face exam in the 31 to 90 days we understand that one would need to be done before the 120th day**

A18: Yes, the patient would need to have a follow-up evaluation before the 120th day to determine benefit from the RAD device. This answer is based on the assumption that the reason the patient changed from a CPAP to RAD is the failure to show clinical benefit with the CPAP device. According to the NCD, continued coverage requires demonstration of therapy benefit within the first 90 days. The LCD recognizes that some patients may require a change in therapy to a RAD device and this transition may happen late in the first 90 day period such that an extension to 120 days is necessary.

Q19: **If compliance is not documented in the first 90 days and the patient then has a new facility-based polysomnogram and face-to-face evaluation with a physician and a new trial period is begun, does a new capped rental period start?**

A19: No. Standard break-in-need rules apply because there has been no change in the underlying condition that necessitates the PAP therapy. Consequently, a new capped rental period does not begin.

Q20: **Would it be considered use of a blanket Advance Beneficiary Notice (ABN) to have all new PAP patients sign an ABN at the beginning of therapy stating that if they do not get a face-to-face evaluation or refuse to get the follow-up re-examination by their treating physician between the 31st and 91st day that Medicare will deny the claim?**

A20: Yes, it would be considered a "blanket" ABN if the notice was presented at the beginning of therapy for the purpose of transferring financial liability to the beneficiary. However, the supplier may issue a voluntary ABN at the start of therapy, or at any time during therapy, to forewarn the beneficiary of the potential for Medicare noncoverage if certain clinical requirements are not met during the trial period. The beneficiary does not select an option box or sign a voluntary ABN, and the voluntary ABN does not transfer liability to the beneficiary.

Beginning on Day 61 of the trial period, if the supplier has knowledge that the beneficiary is not making efforts to meet policy criteria for continued coverage or there is other reason to anticipate that continued coverage will be denied, a mandatory ABN may be issued. The beneficiary should choose an option box, and sign and date the ABN when a mandatory ABN is issued.

This ABN should advise the beneficiary that if, by the 90th day of therapy, s/he does not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face- to- face evaluation), Medicare may deny subsequent claim(s) and the beneficiary will be liable for payment.

Additional information regarding issuance of voluntary and mandatory ABNs can be found in the Internet Only Manual (IOM) 100-04, *Medicare Claims Processing Manual*, Chapter 30, Section 50. This can be accessed via the CMS website: **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html**

Q21: **What can a supplier do if the patient does not get in to see the treating physician within the 31st-91st day?**

A21: If the patient received the re-evaluation at a later date and it was documented that the patient was benefiting from the use of the PAP device, the supplier may begin submitting claims with the KX modifier from the date of that re-evaluation. Claims for services in the interim between the 91st day and the date of the re-evaluation must be submitted with the KX omitted.

Q22: **What can be done in a situation where an order is received for PAP therapy but the patient never had a face-to-face evaluation? Can the face-to-face evaluation be done after the sleep test or after initiation of PAP therapy and will that meet our documentation requirements?**

A22: The NCD and LCD require that prior to initiating PAP therapy; the patient has a clinical evaluation and sleep test. There is a sound clinical rationale for this specific sequence of events; therefore, a face-to-face evaluation performed after the sleep test or after the initiation of PAP therapy would not meet the coverage requirements and a KX modifier must not be added to the claim. Suppliers may obtain an ABN to inform the beneficiary that the PAP device will not be covered since the coverage requirements were not met.

For more information, please refer to the Local Coverage Determinations (LCDs) and related Policy Articles by clicking on the following link: **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

Suppliers should contact the Pricing, Data Analysis, and Coding contractor (PDAC) for guidance on the correct coding of specific items.

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

Historical Review Results

An initial probe was performed for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided. This probe was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor and resulted in a Charge Denial Rate (CDR) of 86%. A summary of findings was published on the NHIC web site on November 30, 2011. Based on this result, a widespread prepayment review was continued.

Current Review Results

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

The review involved prepayment complex medical review of 74 claims submitted by 56 suppliers for claims processed January 2012 to March 2012. Responses to the Additional Documentation Request (ADR) were not received for 5 (7%) of the claims. For the remaining 69 claims, 4 claims were allowed and 65 were denied resulting in a claim denial rate of 94%. 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 90.9%.

Primary Reasons for Denial

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

Lack of Medical Record Documentation

- 78% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 9% of the denied claims were missing the evaluation/assessment documentation for the functional level of item(s) billed (prosthetist assessment).

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

- 11% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 6% of the denied claims were missing the proof of delivery.

Claim Examples

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

Example 1:

Received: The supplier submitted a detailed written order, which includes the beneficiary's name, specific items or components to be dispensed, treating physician's signature, date of clinician's signature and start date of order; proof of delivery which validates that the beneficiary received the items that were billed; an invoice of items that were billed, which includes the manufacturer, model numbers and cost of each item.

Missing: Clinician documentation to support functional level of device and to corroborate the prosthetist's records and the evaluation/assessment documentation for the functional level of item(s) billed.

Example 2:

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

Example 3:

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

Next Step

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

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

Educational References

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

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  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
- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/phy_letter_artificial_limbs.pdf
- August 2011 CERT Errors
  http://www.medicarenhic.com/dme/articles/102111_CERT-Errors.pdf
- CERT Physician Letter - Documentation
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_doc.pdf
- Results of Widespread Prepayment Probe for Lower Limb Prostheses - Posted November 30, 2011
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/113011_llp.pdf

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 602 claims reviewed from June 2011 through September 2011 and resulted in a 73.9% Charge Denial Rate (CDR).

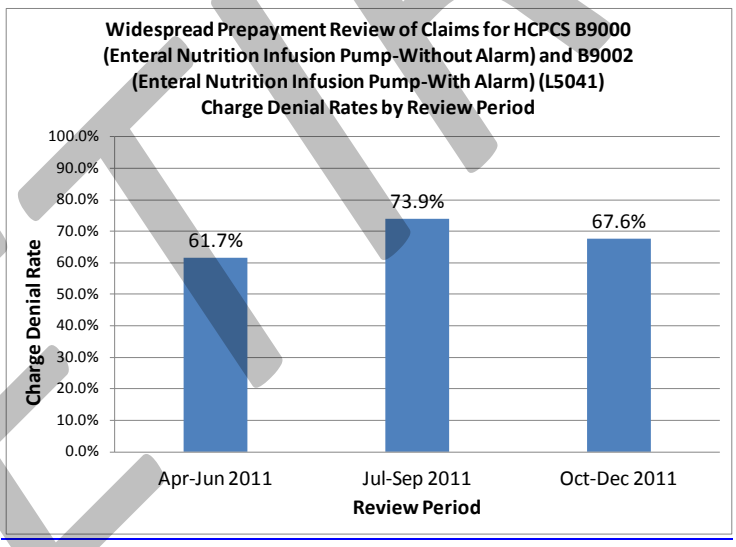
Current Review Results

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 386 claims reviewed from October 2011through December 2011.

The review involved prepayment complex medical review of 378 claims submitted by 111 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 94 (24%) of the claims. For the remaining 284 claims, 90 claims were allowed and 194 were denied/partially denied resulting in a claim denial rate of 68%. 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 67.6%.

Charge Denial Rate Historical Data

The following 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 which are listed from most common to least common. Note that the percentages noted below reflect the fact that a claim could have more than one missing/incomplete item.

Lack of Clinical Documentation:

- 19% of the denied claims had *insufficient* clinical documentation to justify the LCD criteria needed for one or both of the following for enteral nutrition:
  - (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, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.)

- **Note:** *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump*

- 9.5% of the denied claims did not have any medical record documentation submitted

Proof of Delivery Documentation Issues:

- 19.3% of the denied claims had no Proof of Delivery
- 4.2% were missing items such as the enteral pump, feeding kits, or formulas from the delivery ticket.
- 9.5% had delivery dates before the start date on the detailed written order

Detailed Written Order Issues:

- 10.2% of the denied claims had missing detailed written orders.
- 3.2% of the denied claims had an incomplete detailed written signature, date, frequency

DME MAC Informational Form (DIF) Discrepancies:

- 3.5% of the denied claims had an incomplete or missing signature, date of signature

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). Missing progress notes to support the policy coverage criteria for enteral nutrition and the infusion pump per LCD L5041. Proof of delivery is not valid; the enteral pump was not listed as an item delivered.

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: ADR letter with only the beneficiary name
Missing: The detailed written order, medical records, DIF, and delivery ticket.

Next Step

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

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

Educational References:

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

- Enteral Nutrition (L5041) LCD 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 9/30/2011)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/093011_enteral.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
- DME MAC A CERT Physician Letter - Enteral Nutrition
  http://www.medicarenhic.com/dme/CERT/EN_phy_letter_doc.pdf
- DME MAC A Self-Service Tools Enteral Nutrition Units of Service Calculator
  http://www.medicarenhic.com/dme/self-service.shtml
- DME MAC A Frequently Asked Questions (search word enteral)
  http://www.medicarenhic.com/faq_results.asp?categories=DME
- DME MAC A Bulletin 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 June 01, 2011 through August 31, 2011 and resulted in a Charge Denial Rate (CDR) of 56.5%.

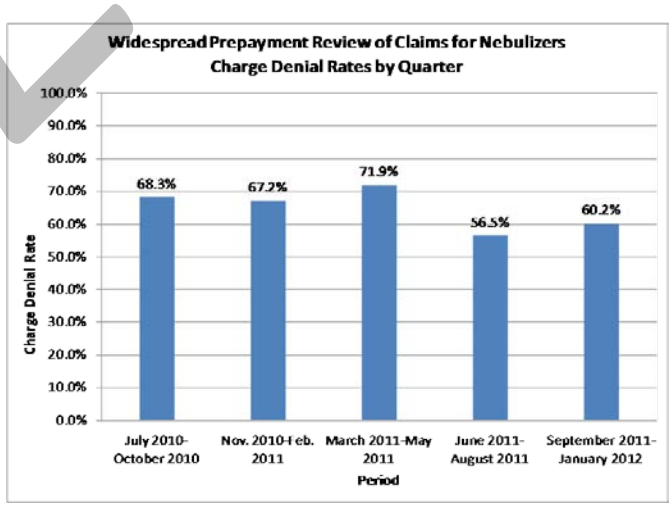
Current Review Results

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 September 2011 through January 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 1,432 claims submitted by 619 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 536 (37%) of the claims. For the remaining 896 claims, 305 claims were allowed and 591 were denied/partially denied resulting in a claim denial rate of 65.9%. 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 60.2%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

Based on review of the documentation received, 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:

- 75.2% of the denied claims were missing any clinical information to support medical necessity. No medical records of any sort were submitted.
- 6.1% of the denied claims had insufficient clinical documentation. The documentation submitted focused on other medical issues unrelated to nebulizers.

Detailed Written Order Issues:

- 6.6% of the denied claims were missing the detailed written order.

Proof of Delivery Issues:

- 24.7% 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 MD order with legible signature and date, Delivery ticket with legible signature
Missing: Clinical documentation selecting reasonable and necessary need of nebulizer equipment

Example 2:

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

Example 3:

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

Next Step

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

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

Educational References:

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

- Nebulizers (L11499) LCD Nebulizers - Policy Article - Effective February 2011(A24944)
- **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**
- Results of Widespread Prepayment Review of Claims for E0570: posted November 11, 2010, March 25, 2011, July 1, 2011 and December 22, 2011.
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml
- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- CERT Physician Letter - Nebulizers
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

- Monthly CERT Error examples (April 2011, May 2011, July 2011)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Frequently Asked Questions (search word nebulizer)
  http://www.medicarenhic.com/faq_results.asp?categories=DME

Results of Widespread Prepayment Review for Home Blood Glucose Monitor Supplies (HCPCS Codes A4253 (BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS) and A4259 (LANCETS, PER BOX OF 100) (LCD L11530)) (SPE)

Historical Review Results

This is the first DME MAC A widespread prepayment complex review for Home Blood Glucose Monitor Supplies (HCPCS Codes A4253 (BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS) and A4259 (LANCETS, PER BOX OF 100). This review was initiated due to high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

Current Review Results

The DME MAC Jurisdiction A has completed the prepayment complex review of claims for Home Blood Glucose Monitor Supplies (HCPCS Codes A4253 (BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS) and A4259 (LANCETS, PER BOX OF 100). These findings cover claims with service dates primarily from August 2011 through February 2012.

The review involved prepayment complex medical review of 4,429 claims submitted by 765 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 1,516 (34%) of the claims. For the remaining 2,913 claims, 622 claims were allowed and 2,061 were denied resulting in a claim denial rate of 71%. 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 $268,836.06 divided by $350,474.46 for a percentage of 76.7%.

Primary Reasons for Denial

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

Medical Necessity Documentation Issues

- 53% (1557) of the denied claims were missing any clinical information to support medical necessity. (No medical records of any sort were submitted.)
- 33% (956) of the denied claims had *insufficient* clinical documentation. The medical record information submitted was insufficient to show that the coverage criteria listed in the local coverage determination (LCD) were met. Examples of insufficient clinical documentation received include:
  - Medical records without explanation of why beneficiary is testing above utilization guidelines
  - Medical records without a diagnosis of diabetes
  - Illegible medical records
  - No beneficiary logs to demonstrate that the patient is testing above utilization guidelines

Other Documentation Issues

- 35% (1019) of the claims were denied for incomplete documentation. Examples include:
  - No evidence of beneficiary training in the use and understanding of the monitor and supplies
  - No proof of beneficiary request for refill
  - No physician order for supplies, or change in frequency of testing

Proof of Delivery

- 5% (140) of the denied claims had delivery documentation issues. Examples include:
  - Missing delivery tickets (no proof patient ever received supplies)
  - Missing supply list (no itemization of what patient received)

Billing Issues

- 10% (285) of the denied claims had issues with correct billing. Examples include:
  - Multiple suppliers billing for the same date of service
  - Duplicate claims being submitted
  - Incorrect use of modifiers

Claim Examples

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

Example 1:

Received: The supplier submitted documentation that included the patient's name, diagnosis, a physician order that was signed and dated, and a delivery ticket.
Missing: Medical records were not included that would support the medical necessity of the glucose supplies. Also missing from the delivery ticket was a listing of the supplies delivered to the patient.

Example 2:

Received: The supplier submitted medical records, the physician's order that was signed and dated, delivery ticket, and invoice of supplies.
Missing: All requested documentation was submitted. However a payable diagnosis was not included on the claim or within the medical records. An appropriate medical diagnosis is necessary to determine the medical need of the glucose supplies.

Example 3:

Received: The supplier submitted all of the required documentation, medical records, payable diagnosis, delivery ticket and invoice.
Missing: The detailed written order was dated after the date of service on the claim and received after the billing date. There was no documentation of a prior dispensing order in the submission.

Next Step

NHIC will continue medical review efforts for glucose supplies for suppliers with high error rates and also continue widespread Documentation Compliance Reviews.

Educational References

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

Suppliers are encouraged to review the following references:

- Glucose Monitor LCD (L11530) and Related Policy Article (A33614)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- The DME MAC Jurisdiction *A Supplier Manual* **http://www.medicarenhic.com/dme/suppmandownload.shtml**
  - "Welcome Page" provides valuable information to the CMS Web sites.
  - Chapter 10: includes information regarding documentation requirements.
- January - November 2011 CERT Error Articles
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Items Provided on a Recurring Basis and Request for Refill Requirements
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/080511_refill.pdf
- Dear Physician Letter for Glucose Monitor Supplies
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_glucose.pdf
- DME MAC A Glucose Monitor Tutorial
  http://www.medicarenhic.com/dme/dme-eduonline.shtml#tutorials

- DME MAC A Glucose Documentation Podcast
  http://www.medicarenhic.com/dme/dme-eduonline.shtml#podcast

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 August 2011 through October 2011 and resulted in a 47.1% Charge Denial Rate (CDR).

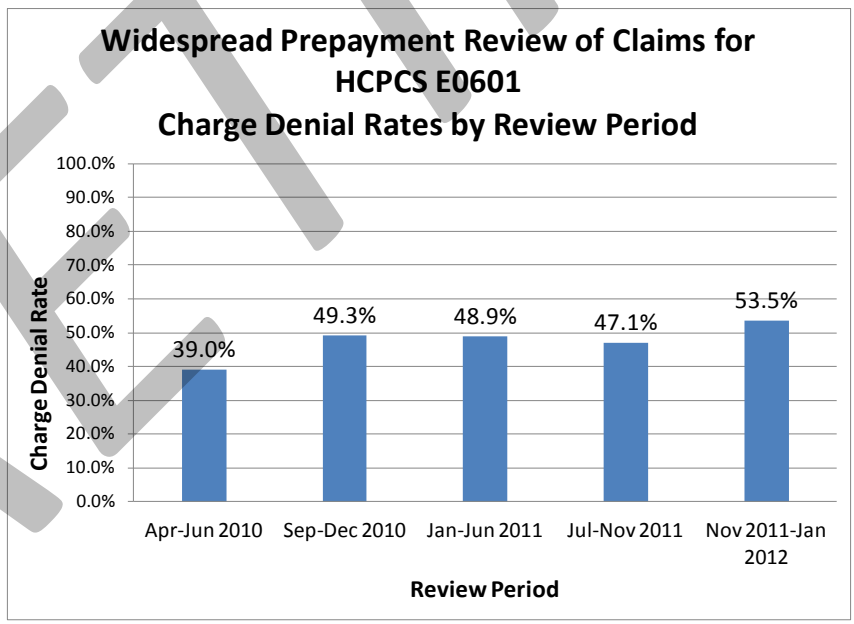
Current Review Results

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 November 2011 through January 2012. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 807 claims submitted by 311 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 322 (40%) of the claims. Of the 485 claims for which responses were received, 208 claims were allowed and 277 were denied/partially denied. This resulted in a claim denial rate of 57%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 53.5%.

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

- 46.5% 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

- 19.8% 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 the claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare

- 6.1% of the denied claims were missing the signature and/or date on the Face to Face clinical evaluation.

- Less than 1% of the denied claims had illegible Face to Face documents.

Detailed Written Order Issues

- 4.7% (or 13) of the denied claims did not include the physician's detailed written order
- 1.8% (or 4) of the denied claims failed to either list all items separately billed or refill/replacement instructions
- 3.2% (or 8) of the denied claims had detailed written orders that were illegible
- 1.4% (or 3.8) of the denied claims had detailed written orders that were not signed/dated by the treating physician

Sleep Study Documentation Issues

- 11.6% of the denied claims did not include a copy of the original Medicare covered sleep study
- 2.2% of the denied claims had sleep study documents that did not meet coverage criteria per the PAP LCD
- 12% of the denied claims had no practitioner's signature on the Medicare approved sleep study interpretation per the PAP LCD
- 1.1% of the denied claims had illegible sleep study documents
- Less than 1% of the denied claims were missing a date on the sleep study documentation

Training Documentation Issues

- 24.5% of the denied claims did not include evidence of training on the PAP device
- 1.8% 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 or via video or telephonic instruction and noted in the record

ABN Issues

- 2.5% of the denied claims included Medicare Waiver of Liability forms that did not meet the criteria for ABN validity for Complex Medical Record Reviews. These documents are not an acceptable substitute for the current ABN; reference CMS-R-131(03/08) Form

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 proof of delivery, evidence of training on the PAP device, a Face to Face clinical evaluation signed by the treating physician, a Medicare approved Sleep Study with clinical findings performed by University Services and three physician detailed order forms for the PAP device.
Missing: The face to face clinical progress note submitted with this claim does not provide sufficient documentation 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. Medicare requires that services provided must be authenticated by the treating practitioner by either a hand written or an electronic signature. There was no real or electronic signature on the Sleep Study test dated 5/10/11 from the prescribing practitioner. This claim did not meet the signature requirement found in the supplier manual.

Example 2:

Received: Included in this claim was proof of delivery, evidence of training on the PAP device, a Face to Face clinical evaluation signed by the treating physician indicating continued and beneficial use of the device and possible need of a replacement machine, MD detailed order, a copy of the original Sleep Study, and the most recent Titration Study to determine need for a replacement PAP device.
Missing: Someone other than the physician may complete the detailed description of the PAP items ordered on the physician's detailed order. However, the treating physician, DO, physician assistant, nurse practitioner, or clinical nurse specialist MUST review the detailed description and personally SIGN and DATE the order to indicate agreement. The MD detailed order dated 6/10/11 submitted with this claim is signed by an RN for the MD (MD name/RN signature). This order is invalid. In addition, the original Sleep Study submitted with this claim is illegible. Reviewer was unable to determine when the study was conducted or if it met the Medicare guidelines for coverage.

Example 3:

Received: Documentation provided with this claim included the physician's detailed order, written confirmation of the verbal order, and a delivery ticket dated 1/18/06.
Missing: This was a claim requesting payment for a replacement device purchased prior to enrolling in Medicare. Documentation not submitted with the claim included the Face to Face clinical evaluation that confirms a diagnosis of OSA and continued use and benefit from the device and the original Sleep Study that meets Medicare coverage requirements. Other missing documentation includes proof of delivery and documentation that beneficiary has received instruction from the supplier on the proper use and care of the PAP equipment.

Next Step

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

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

Educational References

NHIC provides extensive educational offerings related to the proper documentation requirements for E0601 claims. Please ensure that the responsible supplier staff is aware of and references this educational material so that supporting documentation for your claims is compliant with all requirements:

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601): posted 12/22/2011, 8/19/2011, 3/4/2011 and 7/2/2010
  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

- March 2011 CERT Errors
  http://www.medicarenhic.com/dme/articles/050611_CERT-Errors.pdf
- August 2011 CERT Errors
  http://www.medicarenhic.com/dme/articles/102111_CERT-Errors.pdf
- Frequently Asked Questions (search words PAP, CPAP, E0601)
  http://www.medicarenhic.com/faq_results.asp?categories=DME

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

Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from July 01, 2011 through September 30, 2011 and resulted in a 52.5% percent Charge Denial Rate (CDR).

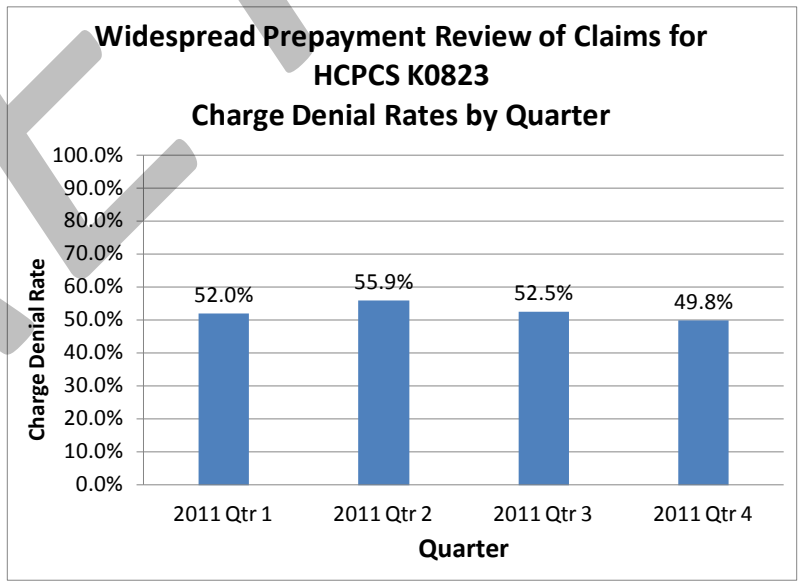
Current Review Results

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

This review involved prepayment complex medical review of 403 claims submitted by 127suppliers. Responses to the Additional Documentation Request (ADR) were not received for 92 (23%) of the ADR requests issued. Of the claims for which responses were received, 153 (51.7%) of the claims were allowed and 143 (48.3%) of the claims were denied. This resulted in a claim denial rate of 48.3%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 49.8%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Insufficient Documentation 46 (32.0%)

- 32 % of the denied claims had insufficient clinical documentation to support medical necessity. The medical record information submitted was insufficient to show that the coverage criteria listed in the Local Coverage Determination (LCD) was met. Examples of insufficient clinical documentation received include:
  - 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
  - Clinical documentation frequently failed to address the possible use or trials of other alternative mobility assistive devices
  - Documentation available from the mobility exam is insufficient as it does not include a comprehensive face to face exam by the prescribing clinician that objectively addresses mobility limitations and provide a clear picture of the patient's mobility deficits. Sufficient objective measurements were not provided
  - Beneficiary's weight is more than the weight capacity of the power wheelchair that is provided

Detailed Product Description Issues 24 (17.0%)

- 17 of the denied claims provided no detailed product description
- 4 of the denied claims were not stamped dated as received by supplier
- 2 of the denied claims were incomplete or incorrect HPCS code indicated on DPD
- 1 of the denied claims had a detail product description dated prior to the 7 Element Order

Multiple Documentation Issues 28 (20.0%) - examples include:

- No treating physician signature on specialty evaluation, no detail product description, no proof of delivery (no delivery ticket), no signature on home assessment by supplier or treating physician
- No 7 Element Order, no proof of delivery (no delivery ticket)
- No treating physician date on specialty evaluation performed, no proof of delivery (no delivery ticket), no 7 Element Order
- No home assessment and financial attestation statement
- No 7 Element Order and financial attestation statement

7 Element Order Issues 21(15.0%)

- 10 of the denied claims did not include all the required 7 elements, example: missing date of Face to Face exam
- 5 of the denied claims did not contain a 7 Element Order
- 2 of the denied claims had illegible 7 Element Orders
- 2 of the denied claims had 7 element orders that did not include confirmation the supplier received a copy within 45 days after the completion of F2F, (as verified by a supplier date stamp or equivalent)
- 1 of the denied claims appeared to be a supplier generated form
- 1 of the denied claims in which the 7 element order and detail product description were on the same form
- 1 of the denied claims had a 7 Element Order dated prior to the Face to Face exam
- Home Assessment Issues 16 (7.0%)
- 13 of the denied claims did not include evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair, (PWC)
- 3 of the denied claims were not signed and dated by either the supplier or the practitioner

Delivery Ticket Issue 5 (4.0%)

- 1 of the denied claims was missing a valid delivery ticket
- 1 of the denied claims had a delivery date before the billing date
- 1 of the denied claims had a delivery ticket which did not match the date of service billed
- 1 of the denied claims had an illegible delivery ticket
- 1 of the denied claims had not date on the delivery ticket

Financial Attestation issues 3 (2%)

- 3 of the denied claims had no financial attestation statement

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 8/16/11

Received: Incomplete 7 Element Order (difficult to read), Certification of Medical Necessity (no longer required), letter of medical necessity, home assessment, mobility evaluation, detail product description, delivery ticket dated 8/12/11 signed by home health aide.

Missing: 7 Element order completed and legible to include the diagnosis for patient, valid delivery ticket signed by beneficiary and date of service corresponds to delivery date.

Example 2: Date of Service 8/26/11

Received: 7 Element Order, physical therapy orders, physical therapy evaluation for wheelchair evaluation, mobility exam in the form of a check off sheet, home assessment, valid delivery ticket.

Missing: Comprehensive medical exam/record in narrative form by treating physician, signed agreement by treating physician of results to physical therapy evaluation, lacking financial attestation indication PT/OT does not have a financial relationship with the supplier and is a result of a referral from the physician, no detail product description.

Example 3: Date of Service 9/13/11

Received: Supplier questionnaire to physician, incomplete 7 Element order (included beneficiary name, description of item to be ordered, and physician signature with date), incomplete progress note, detail product description, supplier invoice, supplier generated forms including valid delivery ticket, home assessment.

Missing: Comprehensive examination in narrative form by treating physician to include patient meeting the weight capacity of the power wheelchair requested (patient is noted to be 75 pounds over the allowance for this Group 2 Power Wheelchair, completed 7 Element order to include beneficiary name, description of item that is ordered, date of Face to Face exam, pertinent diagnosis, length of need, physician signature along with date.

Next Step

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

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

Educational References

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

- Power Mobility Devices (L21271) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Power Mobility Devices - 7-Element Order (published November 05, 2009).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf
- Power Mobility Devices Billing Reminder (published January 11, 2008).
  http://www.medicarenhic.com/dme/articles/011108_pmd.pdf
- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (published 12/15/11, published 08/26/11, published 6/10/11, published 3/11/2011, published 11/5/10).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.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

MLN Special Edition Article #SE1126

"Further Details on the Revalidation of Provider Enrollment Information"

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf

Do NOT submit your revalidation until you are notified to do so by your MAC. You will receive a notice to revalidate between now and March 2015.

Ask-the-Contractor Teleconference (ACT) Q&A - March 27, 2012 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Tuesday, March 27, 2012 as a teleconference/webinar and was based on recent updates and hot topics as well as CEDI and EDI updates. 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: **What documentation is required in the chart when diabetic shoes are dispensed?**
A1: These requirements are listed in the documentation section of the Therapeutic Shoes for Persons with Diabetes LCD. Also, there is a "Dear Physician" letter titled, "Therapeutic Shoes for Diabetics - Physician Documentation Requirements" (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/111110_shoes.pdf**). This letter will provide a listing of documentation required by the certifying physician.

Q2: **Why are there quantity limits on Enteral "B" codes, but the suppliers can't have access to these quantities?**
A2: These limits are classified as MUE's or medically unlikely edits which are kept confidential if set above a certain number (4). If the amount is set below four, it is made public. CMS established the MUE program to reduce payment errors for Medicare Part B claims. Claims processing contractors utilize these edits to assure that providers and suppliers do not report excessive services. The edits are applied during the electronic processing of all claims.

Q3: **How do we determine a patient's jurisdiction?**
A3: The patient's jurisdiction is based on what address is on file with Social Security.

Q4: **How do you bill a claim with more than 4 modifiers?**
A4: If it is a claim for a beneficiary requested upgrade and there are more than four modifiers, replace the fourth modifier with the **KB** and enter the remaining modifiers in the NTE 2400 field. If it is for any other type of claim with more than four modifiers, you would replace the fourth modifier with **99** and enter the remaining modifiers in the NTE 2400 field.

Q5: **If a patient is diabetic and had a below knee amputation on one side, is the shoe for his prosthetic foot covered?**
A5: Yes. Medicare will cover a pair of shoes for the beneficiary assuming all of the coverage criteria are met in the Therapeutic Shoes for Persons with Diabetes LCD.
Note: *Clarification was received on this question after the call and the answer in this document is the official answer.*

Q6: **Can we supply 3 months of diabetic supplies and bill for 3 months, every 3 months?**
A6: Yes. That is acceptable. Remember, you must date span your claim. The "From" and "To" dates are going to be different. i.e., 03/27/2012 to 06/26/2012

Q7: **If a patient tries and fails pap therapy, can the patient be tested via nocturnal oximetry and qualify for nocturnal oxygen?**
A7: No, because the patient is not within a chronic stable state and the LCD requires the testing to be while the patient is within a chronic stable state.

Q8: **How do we notify Medicare if a prepaid customer returns an item?**
A8: You can submit an Overpayment Request Form. You can obtain this form from our web site at:
http://www.medicarenhic.com/dme/dme_forms.shtml

Q9: **If I submit a claim for a quantity over the LCD amount with a "GA" modifier does that mean that none of the units will be paid?**
A9: In this situation the claim should be billed as an upgrade with two lines to ensure you receive correct payment. The units without the **GA** modifier will be paid, assuming the patient meets medical necessity criteria outlined in the LCD and the claim is billed properly.

Q10: **We submit electronic claims and do not receive paper EOBs from primary payors, why are PR22 (MSP) denials not resubmittable?**

A10: Once the system is updated to show Medicare is primary, these claims can be reopened.

Q11: What should suppliers do if a physician refuses to provide information needed to establish medical necessity?
A11: One option is to use the "Dear Physician" letters (**http://www.medicarenhic.com/dme/phy_letters.shtml**) we have on our web site. These are letters written by our medical director, basically, from one doctor to another advising them that it is their obligation to provide this information in order for the patient to be reimbursed for the item they prescribed. Also, you can get the beneficiary involved and have them contact the physician for the information. If they still refuse to provide the documentation, it is your right to refuse to service this patient.

Q12: What is the most common billing error made by providers?
A12: Incorrect modifiers.

Q13: If a patient is on a portable infusion pump (E0781) and has a gap in treatment, how do I mark the certification, initial, recertification, or revised?
A13: It depends on the reason for the break and if you are attempting to obtain a new capped rental or not. If it is a break in medical necessity of 60 days plus the days remaining in the last rental month, it would be a new initial. If it was a break in billing due to a hospital or SNF stay, and something changed on the order, a revised DIF would be required. If nothing has changed, a revised DIF is not necessary.

Q14: "Dear Physician" letters are not effective. Can a company create a handout to the physician that describes medical necessity documentation needs or is this considered coaching? Where is the guidance from Medicare that explains documentation coaching and guidelines and communication for the physicians?
A14: That is the purpose of the "Dear Physician" letters, to help educate them on the documentation requirements of Medicare. Suppliers can also send copies of the LCDs to the physicians.

Q15: Are there sample letters for reordering supplies?
A15: No, but providers can create their own forms.

Q16: How is the PWK segment going to affect the provider community and when is it to be utilized?
A16: POE is creating an article to provide guidance as to when providers should utilize the PWK segment. Contractors are not required to look at the segment in all circumstances and it is therefore not guaranteed that the information will be reviewed. It is suggested that you continue to utilize the NTE segments for additional documentation, when feasible.

Q17: Claims are being rejected as duplicates. They aren't actually being rejected, we are having mismatches with batch totals versus the 277 CA's that are coming back and we are finding these are duplicate claims we are required to fax to CEDI to remove from the duplicate table. Is this a vendor issue or widespread?
A17: CEDI will review information with the provider.

Q18: NHIC DME MAC multiple miscellaneous code billing. We are getting minor denials for incorrect coding when the HCPCS code doesn't have an accurate description and we have to use the K0108 code. Processors are looking at manual wheelchairs and rejecting for incorrect coding.
A18: This is an individual issue and the supplier should contact customer service with examples.

Q19: 277 claim acknowledgement. Medicare secondary claims will process if primary paid on claim. For every claim that primary paid 0, our claims denied stating they need additional information. They don't see the primary EOB information. It is a 277 rejection.
A19: More than likely you are missing a segment in the 5010 transaction, CEDI will contact the provider.

Q20: Does 5010 affect paper claim submission? Does it convert the paper claim when submitted?
A20: If you meet the ASCA requirement, you can continue to submit paper claims. 5010 implementation has no effect on paper claims and they do not need to be converted.

Q21: Once the full 5010 conversion takes place, will the 1500 form change?
A21: No

Q22: I am new to billing and need some information on how to get started with electronic billing.

A22: You can access the CEDI web site at **http://www.ngscedi.com**. You can also speak to someone at the CEDI helpdesk at 866-311-9184.

Q23: What can we do if a physician refuses to provide documentation that is needed to establish medical necessity?
A23: "Dear Physician" letters on our web site will help assist in obtaining this information. You can also get the beneficiary involved and have them assist in obtaining the documentation from the physician.

Q24: Are there any updates on PECOS referring physician editing and when claim denials will begin?
A24: No, a date when the error messages will become claim denials has not been set.

Q25: Is a revision required when a patient initially qualifies for oxygen exertion testing and six months later the physician changes the order to continuous?
A25: No, a revised CMN is not required.

Q26: When a patient passes away prior to delivery, what is the date we use on the claim?
A26: If a custom-made item was ordered but not furnished to a beneficiary because the individual died, or because the order was canceled by the beneficiary, or because the beneficiary's condition changed, and the item was no longer reasonable and necessary or appropriate, payment can be made based on the supplier's expenses. In such cases, the expense is considered incurred on the date the beneficiary died, or the date the supplier learned of the cancellation, or that the item was no longer reasonable and necessary or appropriate for the beneficiary's condition. If the beneficiary died, or the beneficiary's condition changed and the item was no longer reasonable and necessary or appropriate, payment can be made on either an assigned or unassigned claim. If the beneficiary, for any other reason, canceled the order, payment can be made to the supplier only. Therefore, the date of death is the date of service.

Q27: On NHICs web site, there is a PO Box and a street address for reopenings and redeterminations. The street address indicates overnight. Can we use that address for all our correspondence to overnight?
A27: Yes

Q28: Does NHIC have the capability to file redeterminations online with additional documentation electronically?
A28: No, not at this time.

Q29: Please provide clarification on the use of GA and GY modifiers?
A29: The GA indicates that you have a signed and valid ABN on file. The GY modifier indicates that an item is statutorily excluded (noncovered) or does not meet the definition of the Medicare benefit. These modifiers are used in many LCDs to indicate the coverage criteria specified in the LCD are not met (the opposite of the **KX** modifier in those LCDs).

Q30: Must the supplier have the F2F in hand to add the KX modifier to the claim, or can it be obtained at a later date or during an audit?
A30: For power mobility devices, the supplier must have a copy of the face-to-face to bill with the KX modifier. The supplier is also required to date stamp the face-to-face evaluation when received from the physician.

Q31: Where was the FAQ Quick Hit located?
A31: It is located on the home page of NHICs DME MAC web site. Once the home page is refreshed, a new FAQ will appear.

Q32: Do you have any idea how many revalidation letters have gone out and how many have been sent to vision suppliers?
A32: Please contact the NSC for additional details on revalidation.

Q33: For oxygen, there is no face-to-face documentation 30 days prior to the CMN date, but the need for oxygen is present based on the test results, does the patient need to be retested and reevaluated going forward?
A33: Yes. This is one of the top CERT and MR errors. The patient must be seen by the treating physician 30 days prior to the initial date of the CMN and within 90 days of the recertification CMN.

Q34: Could the GA and GY modifier be used concurrently?
A34: No, this would not be appropriate. If a voluntary ABN was obtained for a noncovered item, the GX modifier is appended in addition to the GY.

Q35: **Question in reference to LCDs that don't specify how to handle a patient that is renting equipment with a commercial or HMO insurance and then transitions to FFS. Is it assumed at that point that we need to follow the entire LCD through? Example: Patient was renting a power wheelchair through a commercial insurance and now is Medicare FFS, how do we start to qualify that patient and the LCD doesn't state when a patient is entering FFS as primary?**

A35: If the LCD doesn't list an exception, and the PMD LCD does not, the beneficiary would need to meet all qualification standards outlined in the LCD.

Q36: **What if you have a patient that has a prescription from a doctor for a prosthetic device and prior to delivering the item you request the medical records from their primary care physician and the only records from the primary care physician state that the patient is an amputee. He doesn't have the records from the amputation because it was performed 20 years ago, is this enough information?**

A36: No, it is not enough information. There is a "Dear Physician" letter for lower limb to help provide guidance on what documentation must be in the primary care physician's medical records. One question we receive often is "Can the prosthetist provide the physician with his chart notes and if the physician signs off in agreement to them, would this be sufficient?" The answer is No, that would not be sufficient documentation.

Q37: **We have an initial CMN for oxygen that the doctor completed. When the recertification is due, the doctor will not complete the CMN stating he has not seen the patient within the past year. As a provider, do we have any recourse? What do we need to do since the physician will not sign for a recertification?**

A37: Suppliers need to educate the beneficiary as well that they need to have a visit with their physician prior to their recertification in order for Medicare to reimburse their oxygen claims. This visit will also help to justify continued need and continued use.

Q38: **If a patient has a CPAP outside of warranty, but they are not eligible for a replacement because the five year reasonable useful lifetime is not ended. The manufacturer will not repair the unit; however, they will replace it at a discounted price. How do we bill to get this item replaced?**

A38: Medicare will not cover replacement of the item within the five year reasonable useful lifetime unless the replacement is necessary due to loss, theft or irreparable damage. Medicare would only cover necessary repairs within the 5 year RUL for normal wear and tear. We suggest speaking with the manufacturer about repairing the device and explaining the Medicare guidelines.

Q39: **Can a small provider submit related notes/documentation along with the claim to avoid ADR letters?**

A39: For Medical Review Probes and Documentation Compliance Reviews, you must wait to receive the ADR to provide your documentation. If billing a miscellaneous code, you can provide your documentation with the claim to describe the item billed and provide pricing details.

Q40: **If a patient signs off on an ABN form, do we have to indicate on the claim form the GA modifier?**

A40: Yes, in order to make the patient responsible for the item in question and to receive a PR denial on the claim, you must append the **GA** modifier in this situation.

Clarification on Submission of the Correct "Amount Paid" on Assigned Claims - Item 29 of the CMS-1500 Claim Form or Electronic Equivalent (GEN)

The following instructions apply to "Assigned" Claims Only.

Suppliers are reminded that Item 29 of the CMS-1500 Claim Form or the electronic equivalent is to be completed with the "total amount the patient paid on the covered services only." Any beneficiary payment amount collected for the specific covered items submitted on the claim, (i.e., coinsurance and deductible) should be reflected with the claim submission. Suppliers should not report any money collected on noncovered items, upgraded items, or items expected to be denied as not reasonable and necessary with an ABN on file. In the event Medicare is the secondary payer, suppliers should not report any primary insurance payments in the "Amount Paid" field.

Suppliers are encouraged to follow the instructions above to ensure the beneficiary's Medicare Summary Notice (MSN) reflects the proper payment due to the supplier and any Medicare payment over the total patient responsibility amount will be sent to the beneficiary.

The DME MACs remind suppliers, there is never any certainty if a deductible will or will not be applied to the claim in question. The deductible will be applied based on the first claim to complete processing and not necessarily the claim with the earliest "date of service" in the year. The information available through the eligibility systems is only as current as of the date received and not a guarantee the deductible will be applied to a specific claim. Therefore, suppliers are strongly encouraged to wait and collect the deductible after a claim has been finalized and included on the remittance advice.

DME MAC CERT Taskforce Webinar Q&A Document (GEN)

On December 14, 2011, the comprehensive error rate testing (CERT) Taskforce conducted two webinars over the CERT program and documentation requirements. The team received over 250 questions during the webinar therefore the document is vast in size. The topics of listed Q&A are as follows:

- Overview of CERT Program
- Order requirements
- Medical records
- Request for refill
- Proof of delivery

All Medicare enrolled DMEPOS suppliers are strongly encouraged to review this document to obtain concise and accurate information that is shared among the four DME MAC contractors. To view the document please visit **http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml** and scroll down to the "DME MAC CERT Taskforce Documents" section.

First 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 January through March 2012 are provided in the following table.

Note: *Due to the transition to CEDI, the data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. 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	188,645	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.133.2010BB.NM109.025 Invalid Information for a Missing or Invalid Information with the Payer's ID Number and Receiver's ID Number	84,938	Payer Identifier must be the same value as Receiver Primary Identifier.
X222.351.2400.SV101-7.020 Missing Information within the Detailed description of service	39,739	The narrative information is missing. The procedure code submitted requires narrative information.

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.121.2010BA.NM109.020 Invalid Information for a Subscriber's contract/member number	36,814	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	33,998	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
X222.226.2300.HI01-2.030 Invalid Information within the Primary diagnosis code	30,951	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
X222.484.2430.CAS04.030 Invalid Information within Other Insured's Adjustment Quantity must not be equal to zero	28,144	If a quantity is not being entered, verify with the software vendor that the value is not submitted as zero.
X222.380.2400.DTP03.090 Invalid Information within the Date(s) of service	21,482	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.
X222.380.2400.DTP03.080 Invalid Information within the Future date and Date(s) of service	17,759	The service start/from date is greater than the date this claim was received.
X222.351.2400.SV101-3.020 Missing Information within the Procedure Code Modifier(s) for Service(s) Rendered	17,584	Procedure Modifier must be valid for the Service Date.

First Quarter 2012 - Top Return/Reject Denials (GEN)

The following information is provided in an effort to reduce other initial claim denials. The information represents the top ten (10) return/reject denials for the first quarter of 2012. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from January through March 2012.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	35,220
CO 182 N56 Procedure modifier was invalid on the date of service.	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	14,645
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	3,053

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	2,858
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	2,769
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	2,589
CO 16 M51, N225, N29 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	1,273
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid ordering provider primary identifier.	**Item 17B** - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician.	924
CO 16 N51 Electronic interchange agreement not on file for provider/submitter.	The PTAN/NSC on file is not eligible to submit electronic claims.	759
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	625

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

DME MAC A ListServes (GEN)

The Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) ListServes are used to notify subscribers via email of important and time-sensitive Medicare program information and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DME MAC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly Bulletins and *Supplier Manual* revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that enable DME MAC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DME MAC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the DME MAC A Web site at **http://www.medicarenhic.com/dme/listserve.html**

Quarterly Provider Update (GEN)

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

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 [Month] of 2011 chapters 2, 4, 6, 7, 8, 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!

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

Written Inquiries

DME - Written Inquiries
P.O. Box 9146
Hingham, MA 02043-9146
Written Inquiry FAX: 781-741-3118

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

Note: *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

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

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

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

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

Local Coverage Determinations (LCDs)

Draft LCDs Comments Mailing Address:
Paul J. Hughes, MD
Medical Director
DME MAC Jurisdiction A
75 Sgt. William Terry Dr.
Hingham, MA 02043

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

June 2012
Number 24

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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