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

March 2012
Number 23

General Information

Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process (SE1137) (GEN) 3

April 2012 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7734) (DRU) 5

April 2012 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (MM7638) (GEN) 6

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), Medicare Remit Easy Print (MREP), and PC Print Update (MM7683) (GEN) 9

Claim Status Category and Claim Status Codes Update (MM7670) (GEN) 11

Claims against Surety Bonds for Suppliers of Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies (DMEPOS) (MM7167) (GEN) 12

End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services (MM7064) (GEN) 13

Immediate Recoupment for Fee for Service Claims Overpayments (MM7688) (GEN) 17

Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers (SE1201) (GEN) 18

Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS): Allowing Contract or Non-contract Suppliers to Maintain and Service the Enteral Nutrition Equipment That They Provided in the 15th Continuous Month of Rental (MM7498) (PEN) 20

Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims (SE1138) (GEN) 21

Pharmacy Billing for Drugs Provided "Incident To" a Physician Service (MM7397) (DRU) 22

Preventive Services Educational Resources for Health Care Professionals (SE1142) (GEN) 24

Reasonable Charge Update for 2012 for Splints, Casts, and Certain Intraocular Lenses (MM7628) (O&P) 26

Recovery Audit Program: Medicare Administrative Contractor (MAC)-issued Demand Letters (MM7436) (GEN) 27

The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs) (SE1204) (GEN) 28

Update to Medicare Deductible, Coinsurance and Premium Rates for 2012 (MM7567) (GEN) 30

Updating Beneficiary Information with the Coordination of Benefits Contractor (SE1205) (GEN) 32

Use of Revised Remittance Advice Remark Code (RARC) N103 When Denying Services Furnished to Federally Incarcerated Beneficiaries (MM7678) (GEN) 33

Fee Schedule Updates (GEN) 34

CMS News Flash (GEN) 35

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/

Table of Contents

Medical Review

DME MAC Jurisdiction A Local Coverage Determinations 37

Coding Guidelines for Ankle Foot Orthoses (O&P) 37

Correct Coding - Articulating Digit(s) and Prosthetic Hands (O&P) 38

LCD and Policy Article Revisions - Summary for March 1, 2012 (GEN) 38

Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (PEN) 42

Results of Widespread Prepayment Review for E0570 (Nebulizer, with Compressor) (L11499) (SPE) 44

Results of Widespread Prepayment Review for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439) (OXY) 46

Results of Widespread Prepayment Review of Claims for HCPCS E0601, (Continuous Positive Airway Pressure Devices) (SPE) 49

Standard Documentation Language for Local Coverage Determinations (GEN) 52

Suction Pumps Final Local Coverage Determination Released (SPE) 57

Outreach & Education

2012 DME MAC Jurisdiction A Symposiums 58

DME MAC Symposiums - Knowledge is Key 58

1099-MISC Form Information (GEN) 58

Ask-the-Contractor Teleconference (ACT) Q&A - December 20, 2011 (GEN) 59

Fourth Quarter 2011 - Top Claim Submission Errors (GEN) 66

Fourth Quarter 2011 - Top Return/Reject Denials (GEN) 66

DME MAC A ListServes (GEN) 67

Quarterly Provider Update (GEN) 68

Supplier Manual News (GEN) 68

Legend

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

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

Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process (SE1137) (GEN)

MLN Matters® Number: SE1137 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on January 17, 2012, to add a section to clarify Medicare's capability to cross over HIPAA Version 4010A1 or National Council for Prescription Drug Programs (NCPDP) Version 5.1 batch claims to the Coordination of Benefits Agreement (COBA) supplemental payers that have cut-over to exclusive receipt of claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers that are permitted to submit claims using the CMS 1500 or UB04 hardcopy formats. All other information remains unchanged.*

Provider Types Affected

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

What Providers Need to Know

Supplemental payers are transitioning to HIPAA 5010 or NCPDP D.0 under the National Crossover Process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national COBA crossover process from their production Version 4010A1, HIPAA 837 claims to HIPAA Versions 5010A1 and 5010A2 837 claims. As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their "pre-HIPAA 5010" production Version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to further illustrate this point:

Payer A moved to HIPAA 5010 production on November 7, 2011. Medicare will then systematically transfer to Payer A all "clean" electronically received 4010A1 claims that are already on the payment floor and tagged for crossover as of November 3 and 4, 2011. Beginning with claims that CMS' Coordination of Benefits Contractor (COBC) received that have a file date of November 22, 2011, Medicare, through the COBC, will no longer be able to transfer production 4010A1 claims to payer A. This is because 14 full calendar days have elapsed since Payer A moved into production on the HIPAA 5010 claim formats.

NOTE: *The same premise will hold for inbound Version 5.1 batch NCPDP claims when a supplemental payer moves into production on the NCPDP D.0, Version 5.2 batch format for receipt of crossover claims.*

As provided in CMS Change Requests (CRs) 6658* and 6664*, the COBC activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226 - "4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims."
- N22230 - "NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims."

*To review the entire CR6658, visit **http://www.cms.gov/transmittals/downloads/R1844CP.pdf** on the CMS website.
*To review the entire CR6664, visit **http://www.cms.gov/transmittals/downloads/R1841CP.pdf** on the CMS website.

Providers, physicians, and suppliers should note that they will see the foregoing edit codes on the special provider notification letters that Medicare mails to them at their on-file correspondence address when Medicare is unable to send various claims for crossover purposes. Receipt of these codes on the special provider notification letters denotes that:

1. The patient's supplemental payer has moved into HIPAA 5010 or NCPDP D.0 production receipt for all Medicare crossover claims; and
2. For a limited timeframe (likely 30 days after a supplemental payer cuts over to Version 5010 for crossover claims receipt), providers, physicians, and suppliers will need to file the affected claims directly with their patients' supplemental payers.

Key Points

- Your Medicare contractor will not attempt to repair claims that the COBC returns via the COBC Error Reports with error codes N22226 through N22229, regardless of error percentage.

- Your Medicare contractor will create special provider letters to their affiliate suppliers in association with "production" claims that the COBC rejects with error code N22226 or N22228. Per CMS instruction, these letters indicate that Medicare cannot cross the listed patient-specific claims over to patient's supplemental payer and include a specific "222" error code and accompanying description. MLN Matters® Article MM3709 details the initial CMS instructions to contractors and may be reviewed at **http://www.cms.gov/MLNMattersArticles/downloads/MM3709.pdf** on the CMS website

- Complete details of the COBA Error Notification process are included in the official instruction issued to your Medicare contractor and may be viewed at **http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf** on the CMS website.

- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

Additional Clarification of the Crossover Claims Process

There is some confusion in the provider community concerning whether billing of hardcopy CMS 1500 or UB04 claims or HIPAA Version 4010A1 or NCPDP Version 5.1 batch claims to Medicare will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats.

In other words, there is an assumption being made that billing vendors or physician/practitioner, provider, or supplier offices that bill Medicare will continue to receive error code N22226 for every occasion that they bill claims to Medicare using a hardcopy (paper) claim format (CMS-1500 or UB-04) or Version 4010A1 or NCPDP 5.1 batch formats. **This assumption is incorrect, as explained below.**

During the 90 day non-enforcement period (January 1, 2012—March 31, 2012), Medicare will have the systematic capability to convert incoming claim formats in accordance with external supplemental payer specifications concerning production claims format. That is, Medicare will have the ability to:

- Take incoming claims submitted by the provider community in hardcopy (paper) format or Version 4010A1 or NCPDP 5.1 batch claim formats and convert them to HIPAA Version 5010A1 or 5010A2 claim formats, as appropriate, or NCPDP D.0 batch claim formats for those COBA supplemental payers that already have cut-over to exclusive receipt of Version 5010 COB claims in production; and

- Take incoming claims submitted by the provider community in the Version 5010A1 or 5010A2 or NCPDP D.0 batch claim formats and convert them to HIPAA Version 4010A1 claim formats or NCPDP 5.1 COB batch claim format for those supplemental payers that have not cut-over to production use of the HIPAA Version 5010 COB claim formats or NCPDP D.0 batch claim format.

This action is controlled by information that Medicare's Common Working File (CWF) receives concerning individual supplemental payers' ability to accept HIPAA 5010 or NCPDP D.0 claim formats in "production" mode. **With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of the 90 day non-enforcement period.**

Note: *For physicians/practitioners, providers, and suppliers that have the authorization under the Administrative Simplification Compliance Act (ASCA) to submit claims to Medicare using a hardcopy format, Medicare has the systematic capability to convert*

keyed claims into outbound compliant HIPAA 837 claim formats for crossover claim transmission purposes. ***This is true at all times, not just during the 90 day non-enforcement period.***

Summary

During the 90 day non-enforcement period, Medicare has the ability to take incoming claims formats (hardcopy, Version 4010A1, Version 5010A1 or 5010A2, NCPDP 5.1 batch, or NCPDP D.0 batch) and transform them into alternative Version HIPAA claim or NCPDP claim formats for COB purposes to address the "production" specifications of various supplemental payers. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of 90 day non-enforcement period.

Additional Information

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

If you have any questions about Electronic Data Interchange (EDI) Medicare, customers may call their regional EDI Helpline to access information. These regional toll free numbers may be found in the "Downloads" section of the Electronic Billing & EDI Transactions web page at **http://www.cms.gov/ElectronicBillingEDITrans/** on the CMS website.

April 2012 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7734) (DRU)

MLN Matters® Number: MM7734
Related CR Release Date: January 26, 2012
Related CR Transmittal #: R2396CP

Related Change Request (CR) #: CR 7734
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

Provider Types Affected

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 April 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 April 2, 2012, with dates of service April 1, 2012, through June 30, 2012.

What You Need to Know

Change Request (CR) 7734, from which this article is taken, instructs your Medicare contractors to download and implement the April 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 January 2012, October 2011, July 2011, and April 2011 files.

What You Need to Do

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

Background

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

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
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
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011

Additional Information

You can find the official instruction, Change Request (CR) 7344, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting **http://www.cms.gov/Transmittals/downloads/R2396CP.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.

April 2012 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (MM7638) (GEN)

MLN Matters® Number: MM7638
Related CR Release Date: December 2, 2011
Related CR Transmittal #: R2363CP
Related Change Request (CR) #: 7638
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7638, which provides the DMEPOS April 2012 quarterly update. This update implements necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, and single payment amount files effective April 1, 2012. Be sure your billing staff is aware of these changes.

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

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 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 requires 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 **http://www.cms.gov/DMEPOSCompetitiveBid/** on the CMS website.

Competitive Bidding ZIP Codes

For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA. ZIP codes are established by the United States Postal Service (USPS). The CBA numbers and associated names are as follows:

- 16740 - Charlotte-Gastonia-Concord, NC-SC (non-mail order and mail order)
- 16741 - Charlotte-Gastonia-Concord, NC-SC (mail order only)
- 17140 - Cincinnati-Middletown, OH-KY-IN (non-mail order and mail order)
- 17141 - Cincinnati-Middletown, OH-KY-IN (mail order only)
- 17460 - Cleveland-Elyria-Mentor, OH (non-mail order and mail order)
- 17461 - Cleveland-Elyria-Mentor, OH (mail order only)
- 19100 - Dallas-Fort Worth-Arlington, TX (non-mail order and mail order)
- 19101 - Dallas-Fort Worth-Arlington, TX (mail order only)
- 28140 - Kansas City, MO-KS (non-mail order and mail order)
- 28141 - Kansas City, MO-KS (mail order only)
- 33100 - Miami-Fort Lauderdale-Pompano Beach, FL (non-mail order and mail order)
- 33101 - Miami-Fort Lauderdale-Pompano Beach, FL (mail order only)
- 36740 - Orlando- Kissimmee, FL (non-mail order and mail -order)
- 36741 - Orlando- Kissimmee, FL (mail order only)
- 38300 - Pittsburgh, PA (non-mail order and mail order)
- 38301 - Pittsburgh, PA (mail order only)
- 40140 - Riverside-San Bernardino-Ontario, CA (non-mail order and mail order)
- 40141 - Riverside-San Bernardino-Ontario, CA (mail order only)

Public Use Files

The competitive bidding ZIP codes and single payment amounts per product category and CBA are available on the CBIC website for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The CBIC website can be accessed at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf** or by going to **http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp** on the CMS website. These files can be used to identify when a specific item furnished to a beneficiary is subject to the DMEPOS competitive bidding program.

Single Payment Amount

Currently, Medicare payment for most DMEPOS items is based on fee schedules in most areas of the country. However, the Social Security Act (Section 1847; see **http://www.ssa.gov/OP_Home/ssact/title18/1847.htm** on the Internet) mandates that competitive

bidding single payment amounts replace the current DMEPOS fee schedule payment amounts for competitively bid items in CBAs. Therefore, the single payment amount is the Medicare allowed payment amount for competitively bid items for beneficiaries who reside in the Round One Rebid CBAs. Medicare pays contract suppliers 80 percent of the single payment amount for each competitively bid item. Beneficiaries are responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items. Single payment amounts remain the same throughout the term of suppliers' contracts.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months. The changes to the power wheelchair payment rules made by section 3136 of the Affordable Care Act (see **http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf** on the Internet) do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011, or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the purchase single payment amount (or fee schedule amount for grandfathered suppliers) for the first three months and 75 percent of the single payment amounts (or fee schedule amounts for grandfathered suppliers) paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by the Section 3136 of the Affordable Care Act, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount.

For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.

Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amounts for rented enteral nutrition infusion pumps described by HCPCS code B9000 and B9002, made in accordance with the "*Medicare Claims Processing Manual*" (Chapter 20, Section 40.3; see **http://www.cms.gov/Manuals/downloads/clm104c20.pdf** on the CMS website). The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

Key Points of CR7638

Updates to the ZIP Code Files:
There are no updates to these files at this time

Updates to the HCPCS and Single Payment Amount Files:
There are no updates to these files at this time.

Additional Information

If you have any questions, please contact your Medicare DME MAC or RHHI at their toll-free number, which may be found at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The official instruction associated with this CR7638 issued to your Medicare DME MAC or RHHI regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2363CP.pdf** on the CMS website.

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), Medicare Remit Easy Print (MREP), and PC Print Update (MM7683) (GEN)

MLN Matters® Number: MM7683
Related CR Release Date: December 22. 2011
Related CR Transmittal #: R3372CP

Related Change Request (CR) #: CR 7683
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

Provider Types Affected

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

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 7683 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) 7683 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. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software. Be sure your billing staff is aware of these changes.

What You Need to Do

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) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate 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 transaction. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, appropriate Group Code must be reported as well. Additionally, for transaction 837 COB, CARC must be used.

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.

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) if they are currently being used. 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 Change Request (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 CR7683, Medicare contractors must implement on the date specified on the WPC website.

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

CR7683 lists only the changes that have been approved since the last code update CR (CR 7514 Transmittal 2304), 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 (see above for exception).

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 than a future date. 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 October, and must be implemented, if appropriate, by April 2, 2012.

New Codes - CARC:

Code	Current Narrative	Effective Date
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR).	3/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims (use Group Code OA).	3/1/2012

Modified Codes - CARC:

Code	Modified Narrative	Effective Date
18	Exact duplicate claim/service (Use with Group Code OA).	1/1/2013

Deactivated Codes - CARC:

Code	Current Narrative	Effective Date
141	Claim spans eligible and ineligible periods of coverage.	7/1/2012

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.

CR7683 contains no new, modified, or deactivated RARC codes.

Additional Information

The official instruction, CR7683, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R2372CP.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.

Claim Status Category and Claim Status Codes Update (MM7670) (GEN)

MLN Matters® Number: MM7670 Revised
Related CR Release Date: December 22, 2011
Related CR Transmittal #: R2371CP
Related Change Request (CR) #: 7670
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

Note: *This article was revised on January 30, 2012, to correct the Web address in the beginning of page 2. All other information is the same.*

Provider Types Affected

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

What Providers Need to Know

This article, based on Change Request (CR) 7670, explains that the Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 were updated during the February 2012 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at **http://www.wpc-edi.com/content/view/180/223/** on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 2, 2012. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional Information

If you have 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 official instruction, CR7670, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC and carrier) regarding this change, may be viewed at **http://www.cms.gov/transmittals/downloads/R2371CP.pdf** on the CMS website.

Claims against Surety Bonds for Suppliers of Durable Medical Equipment (DME), Prosthetics, Orthotics and Supplies (DMEPOS) (MM7167) (GEN)

MLN Matters® Number: MM7167
Related CR Release Date: January 20, 2012
Related CR Transmittal #: R403PI

Related Change Request (CR) #:7167
Effective Date: February 21, 2012
Implementation Date: February 21, 2012

Provider Types Affected

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) 7167, which outlines the procedures for CMS to make a claim against a DMEPOS supplier's surety bond. Be certain you are aware of these clarifications.

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 the Centers for Medicare & Medicaid Services (CMS) - within 30 days of receiving written notice to do so - the following amounts up to the full penal sum of the bond:

- The amount of any unpaid claim, plus accrued interest, for which the DMEPOS supplier is responsible; and
- The amount of any unpaid claim, civil monetary penalty (CMP), or assessment imposed by CMS or the Office of the Inspector General (OIG) on the DMEPOS supplier, plus accrued interest.

For purposes of this surety bond requirement, an "unpaid claim" is defined as an overpayment (including accrued interest, as applicable) made by the Medicare program to the DMEPOS supplier for which the supplier is responsible.

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, CR 7167, issued to your DME/MAC regarding this change, may be viewed at **http://www.cms.gov/Transmittals/downloads/R403PI.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.hhs.gov/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.

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

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

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

Note: *This article was revised on December 21, 2011, to clarify the cost report language for low volume facility adjustments on page 6. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

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

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

Patient-level Adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those

variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier Adjustment

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

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

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

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

Facility-level Adjustments

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

Training Add-On

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

Adjustments Specific to Pediatric Patients

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

Treatments furnished to pediatric patients:

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

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

ESRD PPS 4-year Phase-in (Transition) Period

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

The ESRD PPS 4-year Transition Period Blended Rate Determination

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

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

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

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

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

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

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

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

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

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

Three New Adjustments Applicable to the Adult Rate

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

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

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

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

Change in Processing Home Dialysis Claims

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

Therefore, all home dialysis claims:

- Must be submitted by a renal dialysis facility and
- Will be processed as Method I claims.

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

Consolidated Billing

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

Other Billing Reminders

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

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

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

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

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

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

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

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

Additional Information

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

- Attachment 3, which is a list of outlier services;
- Attachment 4, which is a list of DME ESRD Supply HCPCS codes used in for ESRD PPS consolidated billing edits;

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

Also see MM7388 (**http://www.cms.gov/MLNMattersArticles/downloads/MM7388.pdf**) for the criteria for a low volume facility and instructions on how to receive the ESRD low volume adjustment for low volume facilities.

You may also want to review the following articles:

- MLN Matters® article MM7476 (**http://www.cms.gov/MLNMattersArticles/downloads/MM7476.pdf**), which alerts providers to changes to Attachments 4, 5 and 8 of CR7064; and

- MM7497 (**http://www.cms.gov/MLNMattersArticles/downloads/MM7497.pdf**), which informs independent laboratories (ILs) that effective January 1, 2012, CMS has eliminated the requirement for ILs to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. It states that organ disease panels will be paid under the Clinical Laboratory Fee Schedule and will not be subject to the 50/50 rule when billed by ILs.

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

Immediate Recoupment for Fee for Service Claims Overpayments (MM7688) (GEN)

MLN Matters® Number: MM7688 Revised
Related CR Release Date: February 9, 2012
Related CR Transmittal #: R205FM

Related Change Request (CR) #: 7688
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Note: *This article was revised on February 10, 2012, to reflect the revised CR7688 issued on February 9, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7688 were revised. All other information is the same.*

Provider Types Affected

This MLN Matters® article is intended for all Part A, and all Part B Providers, Physicians, and Suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) Durable Medical Equipment (DME MACs),) for services to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 7688 is policy that implements a standard "immediate recoupment" process that gives providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date. See the Key Points section of this article for specifics.

Background

Currently, Medicare contractors begin recoupment of an overpayment on Day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if not paid in full by day 30.

Key Points

The "immediate recoupment" process implemented in CR7688 allows providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to day 31.

Key to understanding this change is that providers who request an immediate recoupment must realize it is considered a voluntary repayment. Also, note the following:

1. Providers who choose immediate recoupment must do so in writing to the contractors.

2. The request may be for:
    a. a one-time request for a specific demanded overpayment (the total amount of the demanded overpayment); or
    b. a permanent request for the specific demanded overpayment and all future overpayments.

3. The request may be submitted via regular mail, facsimile, or e-mail and the request must include the Provider's name, contact phone number, Medicare number and/or National Provider Identifier (NPI), Provider or Chief Financial Officer's signature, demand letter number and what option the provider is requesting.

4. By choosing immediate recoupment, providers must understand that they are waiving their rights to interest under Section 935 of the Medicare Modernization Act (MMA) should the overpayment be reversed at the Administration Law Judge level (ALJ) or subsequent higher levels.

5. Providers can terminate the immediate recoupment process at anytime. The request to terminate must be in writing.

Providers should note that Medicare contractors will not consider any recoupment after Qualified Independent Contractor (QIC) proceedings (30 days after a QIC decision) as voluntary payments. Medicare contractors will follow the rules proscribed by Section 935 of the MMA for all recoupment activity after a QIC decision. These rules are explained in Chapter 3, Section 200 of the "*Medicare Financial Management Manual*" that is available at **http://www.cms.gov/manuals/downloads/fin106c03.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

You may further review all of the specifics of this change along with the applicable manual section changes by reading the official instruction for CR7688 issued to your Medicare contractor. The web address for CR7688 is listed in the Additional Information section of this article.

Additional Information

The official instruction, CR7688, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R205FM.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.

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

MLN Matters® Number: SE1201
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers and suppliers (including residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries.

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

CMS would like to highlight the following limitations:

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.

- Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.

- Portable X-Ray services may only be ordered by a Doctor of Medicine or Doctor of Osteopathy. Portable X-Ray services ordered by any other practitioners will be denied.

MLN Matters® Special Edition Article SE1011 provides further details about edits on the ordering/referring provider information on claims. The article is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf** on the CMS website.

Additional Information

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

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

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

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

MLN Matters® Article MM6421, "*Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)*," is available at **http://www.cms.gov/MLNMattersArticles/downloads/MM6421.pdf** on the CMS website;

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

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

MLN Matters® Number: MM7498 Revised
Related CR Release Date: December 23, 2011
Related CR Transmittal #: R1008OTN
Related Change Request (CR) #: 7498
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: *This article was revised on December 27, 2011, to reflect a revised CR7498. In this article, the CR release date, transmittal number, effective date, and the Web address for accessing CR7498 are revised. All other information is the same.*

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

See the Key Points and Additional Information sections of this article for further details regarding these changes.

Key Points

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

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

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

- Group Code CO.

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

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

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

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

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

Additional Information

The official instruction, CR7498 issued to your DME/ MAC regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R1008OTN.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.

Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims (SE1138) (GEN)

MLN Matters® Number: SE1138 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: *This article was revised on January 13, 2012, to correct the last part of the Background Section. That section incorrectly stated that "simply using Not Otherwise Classified as the description does not pass editing and the claim will be rejected".* ***The claim will not be rejected if "Not Otherwise Classified" is submitted as the description.*** *All other information is unchanged.*

Provider Types Affected

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

What You Need to Know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0 compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required.

Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when Non-Specific Procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all Non-Specific Procedure codes.

Background

The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: "Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name". If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I - 005010X223A2 and 837P - 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

Additional Information

A complete listing of Not Otherwise Classified (NOC) Code Set is available at **http://www.cms.gov/ElectronicBillingEDITrans/40_FFSEditing.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

For 5010/D.O implementation information and deadlines, refer to MLN Matters® Special Edition Article #SE1131, which is available at **http://www.cms.gov/MLNMattersArticles/downloads/SE1131.pdf** on the CMS website.

If you are not ready, consider contacting your Medicare contractor to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices. This software is available at **http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp** on the CMS website. Part A billers may download the free PC-Print software to view and print a compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, Change Request (CR) 7392, "Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates," dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

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

MLN Matters® Number: MM7397 Revised
Related CR Release Date: December 15, 2011
Related CR Transmittal #: R2368CP

Related Change Request (CR) #: 7397
Effective Date: January 1, 2013
Implementation Date: January 1, 2013

Note: *This article was revised on December 16, 2011, to reflect the revised CR7397 issued on December 15. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.*

Provider Types Affected

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

What You Should Know

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

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

Background

Pharmacies billing drugs

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

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

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

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

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

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

Payment limits

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

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

Additional Information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at **http://www.cms.gov/Transmittals/downloads/R2368CP.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.

Preventive Services Educational Resources for Health Care Professionals (SE1142) (GEN)

MLN Matters® Number: SE1142 Revised
Related CR Release Date: NA
Related CR Transmittal #: NA
Related Change Request (CR) #: NA
Effective Date: NA
Implementation Date: NA

Note: *This article was revised on February 21, 2012, to add references to MLN Matters® articles that provide updated information on Preventive Services Coverage. That information was added in the Additional Information section below. All other information remains the same.*

Provider Types Affected

This MLN Matters® Special Edition Articles is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide Medicare-covered preventive services to Medicare beneficiaries.

What You Need to Know

- Use this article as a reference to available educational resources related to Medicare-covered preventive services.
- Make each office visit an opportunity to encourage your patients to receive preventive services for which they are eligible.

Introduction

Medicare covers a wide variety of preventive services and screenings for eligible beneficiaries.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) offers a variety of educational products to help you understand coverage, coding, reimbursement, and billing information related to these services.

1. **MLN Preventive Services Products for Health Care Professionals**
   - ***The Guide to Medicare Preventive Services, Fourth Edition*** - This guide is designed to provide education on Medicare's preventive benefits. It is available as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/mps_guide_web-061305.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.
   - ***Quick Reference Information: Preventive Services*** - This educational tool is designed to provide education on the Medicare-covered preventive services. It is available as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf** on the CMS website.
   - ***Quick Reference Information: Medicare Part B Immunization Billing*** - This educational tool is designed to provide education on Medicare-covered preventive immunizations. It is available in print and as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf** on the CMS website. This product is also available in hardcopy as part of the "Quick Reference Information Resources" hardcopy booklet.
   - ***Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination*** - This educational tool is designed to provide education on the Initial Preventive Physical Examination, also known as the IPPE. It is available as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf** on the CMS website.
   - ***Quick Reference Information: The ABCs of Providing the Annual Wellness Visit*** - This educational tool is designed to provide education on the Annual Wellness Visit (AWV). It is available as a downloadable PDF at **http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf** on the CMS website.

- Preventive Brochures and Fact Sheets - In addition, the MLN offers the following brochures and fact sheets:
  - Annual Wellness Visit,
  - Bone Mass-Measurements,
  - Cancer Screenings,
  - Diabetes-Related Services,
  - Expanded Benefits,
  - Human Immunodeficiency Virus Screening,
  - Mass Immunizers and Roster Billing,
  - Preventive Immunizations, and
  - Tobacco-Use Cessation Counseling Services.

To view the downloadable PDFs for these products, visit the Preventive Services Educational Products PDF page at **http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf** on the CMS website.

Note: *To order hardcopy products, please visit the Preventive Services MLN Educational Products web page at **http://www.cms.gov/MLNProducts/35_PreventiveServices.asp** and go to the "Related Links Inside CMS" section and select "MLN Product Ordering Page."*

MLN Preventive Services Educational Products Web Page - This MLN web page provides descriptions of all MLN preventive service-related educational products and resources designed specifically for Medicare FFS health care professionals. This web page is available at **http://www.cms.gov/MLNProducts/35_PreventiveServices.asp** on the CMS website.

2. **Other CMS Resources**
   - **Prevention General Information Overview** web page is available at **http://www.cms.gov/PrevntionGenInfo** on the CMS website.
   - **CMS Frequently Asked Questions** are available at **http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi** on the CMS website.

3. **Additional Preventive Services**
   Under the Affordable Care Act, CMS has the authority to cover additional preventive services that meet certain criteria through the National Coverage Determination Process. In addition to the websites above, please visit the CMS press release web page at **http://www.cms.gov/apps/media/press_releases.asp** on the CMS website.

Beneficiary Information

Please visit the Medicare.gov web page at **http://www.medicare.gov** for beneficiary-related information and resources you may share with your Medicare patients.

Additional Information

You may also want to review the following related MLN Matters® articles:

- MM7636 (**http://www.cms.gov/MLNMattersArticles/downloads/MM7636.pdf**) alerts providers that effective beginning November 8, 2011, Medicare covers intensive behavioral therapy (IBT) for cardiovascular disease as a new preventive service, including one face-to-face cardiovascular disease risk reduction visit annually when furnished in a primary care setting.

- MM7633 (**http://www.cms.gov/MLNMattersArticles/downloads/MM7633.pdf**) alerts providers that effective beginning October 4, 2011, Medicare covers annual alcohol screening as a new preventive service and, for those that screen positive, up to four brief face-to-face behavioral counseling interventions annually for beneficiaries when furnished in the primary care setting.

- MM7637 (**http://www.cms.gov/MLNMattersArticles/downloads/MM7637.pdf**) alerts providers that, effective beginning October 14, 2011, Medicare covers annual depression screening for adults as a new preventive service when furnished in a primary care setting.

Reasonable Charge Update for 2012 for Splints, Casts, and Certain Intraocular Lenses (MM7628) (O&P)

MLN Matters® Number: MM7628
Related CR Release Date: November 18, 2011
Related CR Transmittal #: R2349CP

Related Change Request (CR) #: CR 7628
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs)) for splints, casts, and certain intraocular lenses.

What Providers Need to Know

Change Request (CR) 7628, on which this article is based, announces that payment of claims for splints, casts, and for intraocular lenses implanted in a physician's office (codes V2630, V2631, V2632) continues to be made on a reasonable charge basis subject to certain payment limits. CR7628 also announces that the update factor for the Inflation Indexed Charge (IIC) for 2012 is 3.6 percent.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, and intraocular lenses (codes V2630, V2631, and V2632) implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare Physician Fee Schedule for the procedure for applying the splint or cast.

CR7628 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in Calendar Year 2012. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501.

The Inflation Indexed Charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June 30, 2011. The 2012 payment limits for splints and casts will be based on the 2011 limits that were announced in CR7225 last year, increased by 3.6 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2011. (You can read the MLN Matters® article associated with CR7225 at **http://www.cms.gov/MLNMattersArticles/downloads/MM7225.pdf** on the Centers for Medicare & Medicaid (CMS) website.) The IIC update factor for 2012 is 3.6 percent.

A list of the 2012 payment limits for splints and casts are listed in the table that follows.

2012 Payment Limits for Splints and Casts							
A4565	$8.12	Q4013	$14.88	Q4026	$111.41	Q4039	$7.78
Q4001	$46.21	Q4014	$25.08	Q4027	$17.85	Q4040	$19.44
Q4002	$174.65	Q4015	$7.44	Q4028	$55.72	Q4041	$18.88
Q4003	$33.19	Q4016	$12.54	Q4029	$27.29	Q4042	$32.23
Q4004	$114.91	Q4017	$8.60	Q4030	$71.83	Q4043	$9.45
Q4005	$12.24	Q4018	$13.71	Q4031	$13.64	Q4044	$16.12
Q4006	$27.58	Q4019	$4.31	Q4032	$35.91	Q4045	$10.96
Q4007	$6.13	Q4020	$6.86	Q4033	$25.45	Q4046	$17.63
Q4008	$13.79	Q4021	$6.36	Q4034	$63.30	Q4047	$5.47
Q4009	$8.17	Q4022	$11.48	Q4035	$12.72	Q4048	$8.82
Q4010	$18.39	Q4023	$3.20	Q4036	$31.66	Q4049	$2.00
Q4011	$4.08	Q4024	$5.74	Q4037	$15.53		
Q4012	$9.20	Q4025	$35.68	Q4038	$38.90		

Additional Information

You can find the official instruction, CR7628, issued to your carrier, FI, MAC by visiting **http://www.cms.gov/Transmittals/downloads/R2349CP.pdf** on the CMS website.

Detailed instructions for calculating:

1. **Reasonable charges** are located in the "*Medicare Claims Processing Manual*," Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);
2. **Customary and prevailing charges** are located in "*Medicare Claims Processing Manual*," Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and
3. The **IIC** are located in "*Medicare Claims Processing Manual*," Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).

Chapter 23 of the "*Medicare Claims Processing Manual*" is available at **http://www.cms.gov/manuals/downloads/clm104c23.pdf** on the CMS website.

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

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

MLN Matters® Number: MM7436 Revised
Related CR Release Date: January 6, 2012
Related CR Transmittal #: R202FM
Related Change Request (CR) #: 7436
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: *This article was revised on January 9, 2012, to reflect the revised CR7436 issued on January 6, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7436 were revised. All other information is the same.*

Provider Types Affected

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

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

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

Additional Information

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

To see the official instruction (CR7436) issued to your Medicare contractor, see **http://www.cms.gov/Transmittals/downloads/R202FM.pdf** on the CMS website.

The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs) (SE1204) (GEN)

MLN Matters® Number: SE1204 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 February 29, 2012, to add Hawaii and several territories to ZPIC Zone 1 and to add Puerto Rico and the Virgin Islands to ZPIC Zone 7 of the table on page 2. All other information is the same.*

Provider Types Affected

This Special Edition MLN Matters® Article is intended for all physicians, providers, and suppliers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment (DME) MACs, and Home Health and Hospice (HH+H) MACs for services and supplies provided to Medicare beneficiaries.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP). MIP was established, in part, to strengthen the Centers for Medicare & Medicaid Services' (CMS') ability to detect and deter potential fraud, waste, and abuse in the Medicare program. MIP allows CMS to carry out program safeguard functions effectively and efficiently. As part of this program, CMS created new entities, Program Safeguard Contractors (PSCs), to perform program integrity functions.

On December 8, 2003, the Medicare Modernization Act (MMA) was signed into law. Section 911 of the MMA directed implementation of Medicare Fee-For-Service Contracting Reform. This required CMS to use competitive procedures to replace its current FIs and carriers with a uniform type of administrative entity, referred to as Medicare Administrative Contractors (MACs).

As a result of these changes, seven program integrity zones were created based on the newly-established MAC jurisdictions. New entities entitled Zone Program Integrity Contractors (ZPICs) were created to perform program integrity functions in these zones for Medicare Parts A, B, Durable Medical Equipment Prosthetics, Orthotics, and Supplies, Home Health and Hospice and Medicare-Medicaid data matching. Medicare Part C and D program integrity efforts are handled separately by one national contractor known as the Medicare Drug Integrity Contractor (MEDIC) (Health Integrity, LLC is the current MEDIC). The ZPICs and the MEDIC work under the direction of the Center for Program Integrity(CPI) in CMS.

The following table lists all of the ZPICs and their zones.

ZPIC	Zone	States in Zone
Safeguard Services (SGS)	1	California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
AdvanceMed	2	Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska
Cahaba	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
Health Integrity	4	Colorado, New Mexico, Texas, and Oklahoma
AdvanceMed	5	Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia
Under Protest	6	Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut
Safeguard Services (SGS)	7	Florida, Puerto Rico, Virgin Islands

Medicare Fraud

Fraud frequently arises from false statements or misrepresentations made that are material to entitlement or payment under the Medicare Program. A violator may be a provider, a beneficiary, or an employee of a provider or some other business entity including a billing service. Providers have an obligation, under law, to conform to the requirements of the Medicare Program. Fraud committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, a wide range of administrative sanctions (such as deactivation or revocation of Medicare enrollment or billing privileges, suspension of payments, or exclusion from participation in the Medicare Program) and civil monetary penalties may be imposed when facts and circumstances warrant such action. An investigation that demonstrates potential fraud may be referred to law enforcement for further investigation.

Contacts for Reporting Potential Fraud

Beneficiaries may report Medicare fraud by calling 1-800-MEDICARE or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) hotline at 1-800-HHS-TIPS (1-800-447-8477). Providers may report fraud by calling the DHHS Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

ZPIC Functions

The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC. Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare Program include:

- Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
- Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System;
- Performing medical review, as appropriate;
- Performing data analysis in coordination with CPI's Fraud Prevention System;
- Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

In performing these functions, ZPICs may, as appropriate:

- Request medical records and documentation;
- Conduct an interview;
- Conduct an onsite visit;
- Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;
- Withhold payments; and,
- Refer cases to law enforcement.

ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider. Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at **http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf** on the CMS website.

Non-ZPIC Functions

The following are some of the major functions that the ZPICs do not perform. These functions are performed by the MAC:

- Claims processing, including paying providers/suppliers;
- Provider outreach and education;
- Recouping monies lost to the Trust Fund (the ZPICs identify these situations and refer them to the MACs for the recoupment);
- Medical review not for benefit integrity purposes;
- Complaint screening;
- Claims appeals of ZPIC decisions;
- Claim payment determination;
- Claims pricing; and
- Auditing provider cost reports.

Additional Information

More information about Medicare contracting reform is available at **http://www.cms.gov/MedicareContractingReform** on the CMS website.

The Medicare Learning Network® (MLN) brochure titled "*The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers*," which is designed to provide education on the Medicare Part A and B administrative appeals process, is available at **http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf** on the CMS website.

The MLN fact sheet titled "*Medicare Fraud & Abuse: Prevention, Detection, and Reporting*," which is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse, is available at available at available at **http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf** on the CMS website.

For the latest educational products designed to help Medicare Fee-For-Service providers understand - and avoid - common billing errors and other improper activities, please visit the MLN Provider Compliance web page at **http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp** on the CMS website.

Update to Medicare Deductible, Coinsurance and Premium Rates for 2012 (MM7567) (GEN)

MLN Matters® Number: MM7567 Revised
Related CR Release Date: December 16, 2011
Related CR Transmittal #: R74GI

Related Change Request (CR) #: CR 7567
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: *This article was revised on December 19, 2011, to reflect a revised CR7567 issued on December 16, 2011. In the article, the CR release date, transmittal number, and the Web address for accessing CR7567 were revised. All other information is the same.*

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7567, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2012. Be sure billing staffs are aware of these updates.

Background

2012 Part A - Hospital Insurance (HI)

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Note: *An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.*

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness. **The 2012 inpatient deductible is $1,156.00.** The coinsurance amounts are shown below in the following table:

Hospital Coinsurance		Skilled Nursing Facility Coinsurance
Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
$289.00	$578.00	$144.50

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2012 Part A premiums are as follows:

Voluntary Enrollees Part A Premium Schedule for 2012	
Base Premium (BP)	$451.00 per month
Base Premium with 10% Surcharge	$496.10 per month
Base Premium with 45% Reduction	248.00 per month (for those who have 30-39 quarters of coverage)
Base Premium with 45% Reduction and 10% Surcharge	$272.80 per month

2012 Part B - Supplementary Medical Insurance (SMI)

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

- Standard Premium: $99.90 a month
- Deductible: $140.00 a year
- Coinsurance: 20 percent

In addition, some beneficiaries may pay higher premiums based on their incomes. These amounts change each year. There may be a late-enrollment penalty.

Additional Information

The official instruction, CR7567, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.gov/Transmittals/downloads/R74GI.pdf** on the CMS website.

If you have any questions, please contact your carriers, 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.

Updating Beneficiary Information with the Coordination of Benefits Contractor (SE1205) (GEN)

MLN Matters® Number: SE1205
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 physicians, other providers, and suppliers who provide products or services to Medicare beneficiaries with insurance in addition to Medicare.

Provider Action Needed

Impact to You

A new Medicare Secondary Payer (MSP) initiative will affect how you may update beneficiary information to the Coordination of Benefits Contractor (COBC).

What You Need to Know

This article describes initiatives that both the Centers for Medicare & Medicaid Services (CMS) and the COBC are undertaking to maintain the most up-to-date and accurate beneficiary MSP information on Medicare's Common Working File (CWF).

What You Need to Do

You should make sure that your appropriate staffs are aware of these options for updating a beneficiary's MSP information.

Background

There has been considerable discussion about the accuracy of beneficiary Medicare Secondary Payer (MSP) information on the CWF and who is responsible for keeping that information updated. Further, providers have stated that the update is not accepted when they attempt to update beneficiary information with the COBC by phone.

Therefore (as noted below), CMS and the COBC are both undertaking initiatives to resolve the issue and maintain the most up-to-date and accurate beneficiary information with regard to MSP.

CMS Initiatives

In compliance with Section 111 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 (known as Section 111 of the MMSEA), CMS has implemented a process through which private insurers (both Group Health Plans (GHP) and Non Group Health Plans (NGHP)) submit coverage information to the COBC when they also provide coverage to a Medicare beneficiary. A private GHP insurer reporting under Section 111 is known as a Responsible Reporting Entity (RRE), and the COBC receives Section 111 data input files from approximately 1,500 GHP insurers, and each file can include large numbers of individual coverage records.

This information permits CMS to more accurately determine who (either the private insurer or Medicare) has primary, or secondary, claims coverage responsibility.

Occasionally, information submitted to the COBC from any number of sources, including GHP RREs, service providers, and beneficiaries themselves can conflict with MSP information previously reported to the COBC. To reduce such conflicts in the future, CMS has developed and implemented a data management "Reporting Hierarchy" process, which the COBC administers (effective April 1, 2011). An explanation of the Hierarchy rules can be found at **http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf** on the CMS website.

COBC Initiatives

The COBC works closely with GHP RREs and other reporters in order to reduce "hierarchy" conflicts in future reporting. The following steps are in place to help providers update MSP records:

- **Provider attempting update with the beneficiary in the office:**
  The first time a call is made to update the record after April 4, 2011, it will be updated via the telephone call. For any subsequent calls made to update the record after April 4 2011, no update will be made on the call, but two options are

available: 1) Proof of information can be faxed or mailed on the insurer or employer's company letterhead, and the update will be made in 10-15 business days; or 2) You can contact the insurer or employer organization that last updated the record.

- **Provider attempting update when the beneficiary is not in the office:**
  No update will be made from a telephone call. The provider has 3 options to have the record updated:
  1. Have the Beneficiary contact COBC;
  2. Contact the Beneficiary's insurer to resolve the issue; or
  3. Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

- **Provider with new information:**
  The COBC will take new information for a Beneficiary, but if the new information requires changes to an existing record, two options are available:
  1. The Beneficiary will need to call to close out the record; or
  2. Fax or mail proof of information on the insurer or employer's company letterhead and the update will be made in 10-15 business days.

- **Provider update for deceased beneficiary:**
  A SINGLE update can be made by ONE provider for a Deceased Beneficiary, once the date of death has been confirmed. Any subsequent updates would need to be handled by a family member with the appropriate documentation, including a death certificate.

Additional Information

An explanation of the GHP RRE Hierarchy rules can be found at **http://www.cms.gov/MandatoryInsRep/Downloads/GHpHierarchy.pdf** on the CMS website.

General information about Mandatory Insurer Reporting is available at **http://www.cms.gov/mandatoryinsrep** on the CMS website. The COBC's contact information is:

Telephone:
1-800-999-1118 (8 AM to 8 PM Eastern Time)

Fax:
1-734-957-9598 (address the fax to Medicare Coordination of Benefits)

Mailing address:
Medicare - Coordination of Benefits
P.O. Box 33847
Detroit, MI 48232

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

MLN Matters® Number: MM7678
Related CR Release Date: January 6, 2012
Related CR Transmittal #: R1012OTN

Related Change Request (CR) #: 7678
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

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/R1012OTN.pdf** on the CMS website.

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

Fee Schedule Updates (GEN)

The 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:

- 1st Quarter 2012 Jurisdiction A DME MAC Fee Schedule
- 1st Quarter 2012 Average Sales Price Medicare Part B Drug Pricing File
- 1st 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.

CMS News Flash (GEN)

The Centers for Medicare & Medicaid Services (CMS) has made changes to the Medicare Overpayment Notification Process. If an outstanding balance has not been resolved, providers previously received three notification letters regarding Medicare Overpayments, an Initial Demand Letter (1st Letter), a Follow-up-Letter (2nd Letter), and an Intent to Refer Letter (3rd Letter). CMS would send the second demand letter to providers 30 days after the initial notification of an overpayment. Recent review has determined that the majority of providers respond to the initial demand letter and pay the debt. Currently recoupment action happens 41 days after the initial letter. The remittance advice which describes this action serves as another notice to providers of the overpayment. Therefore, effective Tuesday, November 1, 2011, the second demand letters are no longer being sent to providers. Provider appeal rights will remain unchanged. If an overpayment is not paid within 90 days of the initial letter, providers will continue to receive a letter explaining CMS' intention to refer the debt for collection.

Vaccinate Early to Protect Against the Flu /2011-2012 Influenza Vaccine Prices Are Now Available - CDC recommends a yearly flu vaccination as the most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Under Medicare Part B, Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And don't forget to immunize yourself and your staff. Get the Flu Vaccination - Not the Flu. CMS has posted the 2011-2012 seasonal influenza vaccine payment limits at: **http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp** on the CMS website. Influenza vaccine is NOT a Part D-covered drug. For information about Medicare's coverage of the influenza vaccine, its administration, and educational resources for healthcare professionals and their staff, visit **http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp** on the CMS website

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

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

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!

Protect Your Patients. Protect Your Family. Protect Yourself. Flu seasons are unpredictable and can be severe. Each year, approximately 90 percent of seasonal flu-related deaths and more than 60 percent of seasonal flu-related hospitalizations occur in people 65 years and older. Please encourage your Medicare patients to get an annual flu shot. A flu shot is important for healthcare workers too, who may spread the flu to high risk patients. 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 educational provider resources, visit the following CMS webpages: Medicare Learning Network® Preventive Services and Immunizations. **Get the Flu Vaccine - Not the Flu**.

New product from the Medicare Learning Network® (MLN) "*Medicare Fraud & Abuse: Prevention, Detection, and Reporting***,"** (**http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf**) Fact Sheet, ICN 0006827, downloadable

It's a Busy Time of Year. Make each office visit an opportunity to remind your patients about the importance of getting the seasonal flu vaccination and a one-time pneumococcal vaccination. Medicare pays for these vaccinations for all beneficiaries with no co-pay or deductible. The Centers for Disease Control and Prevention also recommends that 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 educational provider resources, visit the following CMS web pages Medicare Learning Network® Preventive Services and Immunizations. **Get the Flu Vaccine - Not the Flu.** For the 2011-2012 seasonal flu vaccine payment limits, visit **http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp**.

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 Medicare's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "*Further Details on the Revalidation of Provider Enrollment Information*."

Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit **http://www.cms.gov/MLNProducts/downloads/MLNProducts_listserv.pdf** and start receiving updates immediately!

MLN Special Edition Article #SE1126

"Further Details on the Revalidation of Provider Enrollment Information"

http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf

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

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

Coding Guidelines for Ankle Foot Orthoses (O&P)

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Pricing, Data Analysis and Coding (PDAC) contractor received questions regarding coding guidelines for Ankle Foot Orthoses. In an effort to address these questions, the following definitions for certain orthoses will clarify their meaning and assist suppliers in correct coding of these devices.

L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL

A pre-tibial shell, custom fabricated, provides a rigid overlapping interlocking anterior tibial control between the tibial tuberosity to a point no greater than 3 inches proximal to the medial malleolus. The pre-tibial shell can be constructed from thermosetting materials, thermoplastics, or composite type materials.

L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT

A multiligamentous ankle support provides control of the ankle joint between the medial and lateral malleoli while allowing for dorsiflexion and plantar flexion. This off-the-shelf ankle support includes a rigid stirrup and foot plate which provides functional tracking of the ankle with hind-foot and mid-foot stability during ambulation. This, in conjunction with wrap-around straps and the inherent gauntlet design, offers areas of multiligamentous support as described by the code. There are no additional HCPCS codes for this type of prefabricated ankle orthosis.

L1960 ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM-FABRICATED

An Ankle Foot Orthosis (AFO) provides ankle control for patients with musculoskeletal or neuromuscular dysfunction. The AFO is designed to provide rigid immobilization of the ankle-foot complex in the sagittal, coronal, and transverse planes. The custom fabricated solid ankle AFO can be constructed from thermosetting materials, thermoplastics, or composite type materials. The proximal boarder of an Ankle Foot Orthosis (L1960) shall extend to a height no greater than 1.5 inches distal to the apex of the head of the fibula.

Effective for claims with dates of service on or after April 1, 2012, the only products which may be billed to Medicare using code L1906 (ANKLE FOOT ORTHOSIS, MULTILIGAMENTUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT) are those for which a written coding verification has been made by the PDAC contractor and that are listed in the Product Classification Matrix of the DME Coding System (DMECS) maintained on the PDAC website, **https://www.dmepdac.com/dmecsapp/do/search**. Products which have not received coding verification review from the PDAC must be billed with code A9270.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: **https://www.dmepdac.com/**

This information will be added to a future revision of the AFO LCD and related policy article.

Correct Coding - Articulating Digit(s) and Prosthetic Hands (O&P)

Two new codes were released by the Centers for Medicare & Medicaid Services as part of the HCPCS 2012 Annual Release. These codes are effective for dates of service on or after January 1, 2012. The new codes are:

- L6715 TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT
- L6880 ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S).

HCPCS code L6715 describes multiple articulating digit(s) (fingers and/or thumb) which are used on initial issue when paired with a partial hand base procedure code (L6000, L6010, L6020). The articulating digit(s) can also be used as a "replacement digit(s)" with the use of the RB modifier as part of a prosthetic repair. The following base procedure codes include a custom fabricated socket.

- L6000 PARTIAL HAND, THUMB REMAINING
- L6010 PARTIAL HAND, LITTLE AND/OR RING FINGER REMAINING
- L6020 PARTIAL HAND, NO FINGER REMAINING

HCPCS Code L6025 (TRANSCARPAL/METACARPAL OR PARTIAL HAND DISARTICULATION PROSTHESIS, EXTERNAL POWER, SELF-SUSPENDED, INNER SOCKET WITH REMOVABLE FOREARM SECTION, ELECTRODES AND CABLES, TWO BATTERIES, CHARGER, MYOELECTRIC CONTROL OF TERMINAL DEVICE) describes a complete prosthesis. This base procedure code includes all necessary components. This base procedure code includes a custom fabricated socket. The use of L6715 on initial issue will be denied as unbundling.

HCPCS code L6880 describes a complete hand prosthesis, which consists of the terminal device, all articulating digits and motors. This base procedure code does not include a custom fabricated socket. This base procedure code includes all necessary components. The use of L6715 on initial issue will be denied as unbundling.

HCPCS code L7499 (UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED) must not be used for the billing of any additional features or components, programming, adjustment, etc. with L6025 or L6880 as these codes are considered all-inclusive. The use of L7499 on initial issue will be denied as unbundling.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: **https://www.dmepdac.com/**

LCD and Policy Article Revisions - Summary for March 1, 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: 01/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

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

Changed: Word "Patient" to "Beneficiary"

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

Immunosuppressive Drugs

LCD

Revision Effective Date: 01/01/2012

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)

HCPCS CODES:

Added: J8561

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 and proof of delivery requirements

Intravenous Immune Globulin

LCD

Revision History Effective Date: 01/01/2012

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)

HCPCS CODES:

Added: J1557

Revised: J1561 narrative

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

Lower Limb Prostheses

LCD

Revision Effective Date: 01/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE

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

Changed: Word "Patient" to Beneficiary"

HCPCS CODES AND MODIFIERS

Added: L5312

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

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision History Effective Date: 01/01/2012

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)

HCPCS CODES:

Added: Q0162

Deleted: Q0179

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 and proof of delivery requirements

Ostomy Supplies

LCD

Revision History Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Order requirement language to specify a "detailed written order"
HCPCS CODES:
Added: A5056 and A5057
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: General medical record information requirements and proof of delivery requirements

Suction Pumps

LCD

Revision Effective Date: 04/15/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: Preamble
Added: A9272 (effective 01/01/2012)
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
Added: Gastric pump (E2000) coverage statement
Removed: Extra supplies statement
Added: Coverage statement about K0743 and related supplies
Revised: "Reasonable and necessary" for "medically necessary"
HCPCS CODES AND MODIFIERS
Added: A9272
Added: K0743 - K0746 (Effective 07/01/2011)
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

PA

Revision Effective Date: 01/01/2012
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit Category Statement
Added: A9272 to noncovered statement about disposable devices.
CODING GUIDELINES:
Added: K0743 - K0746
Added: PDAC review requirement for K0743
Added: A9272
Revised: A9270 to exclude A9272 devices

Wheelchair Options/Accessories

LCD

Revision Effective Date: 01/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Order requirement
Added: E0988, E2358, E2359
HCPCS CODES AND MODIFIERS:
Added: E0988, E2358, E2359

Replaced: "Patient" with "beneficiary"

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

PA

Revision Effective Dated: 01/01/2012

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: E2359

CODING GUIDELINES:

Added: E0988

Clarified: billing instructions for Power Wheelchairs for armrests versus separate billing for detachable adjustable height armrests: corrected K0020 and added as adjustable. Removed K0020 from bundling table.

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.*

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

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

Historical Review Results

DME MAC A Medical Review continues to review B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm), based on the results of the previous prepayment widespread review. The previous review included claims reviewed from April 01, 2011 through June 30, 2011 and resulted in a 61.7% Charge Denial Rate (CDR).

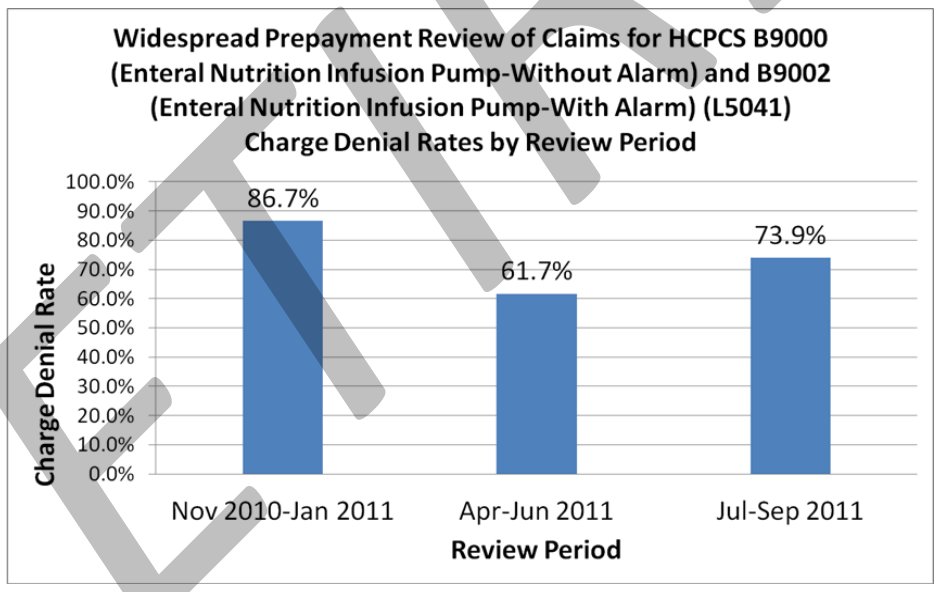
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm). These findings include claims reviewed from July 01, 2011 through September 30, 2011.

The review involved prepayment complex medical review of 602 claims submitted by 159 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 155 (26%) of the claims. For the remaining 447 claims, 134 claims were allowed and 313 were denied/partially denied resulting in a claim denial rate of 70%. 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 73.9%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

Based on 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:

43% 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 permanent non-function or disease of the structures that normally permit food to reach the small bowel
  - 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.*

- 26% of the denied claims did not have any medical record documentation submitted

Proof of Delivery Documentation Issues:

- 21% of the denied claims had no proof of delivery
- 2.6% were missing items such as the enteral pump, feeding kits, or formulas from the delivery ticket
- 9.6% of the denied claims had missing beneficiary names, dates, and/or signatures of recipients

Detailed Written Order Issues:

- 6.4% of the denied claims had missing detailed written orders
- 5.1% of the denied claims had an incomplete detailed written order
- 2.6% had delivery dates before the MD order

DME MAC Informational Form (DIF) Discrepancies:

- 2.6% of the denied claims did not have the HCPCS code documented on the DIF
- 7.7% of the denied claims had an incomplete or missing DIF

Other Submission Issues:

- 3.8% of the denied claims were due to the illegibility of dates, signatures and medical records; and beneficiaries either refusing the pump at delivery, or not using the supplies

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 the beneficiary name only.
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 general coverage and documentation requirements
  http://www.medicarenhic.com/dme/suppmandownload.shtml

- *CERT Physician Letter - Enteral Nutrition*
  http://www.medicarenhic.com/dme/CERT/EN_phy_letter_doc.pdf

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

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

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

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

Historical Review Results

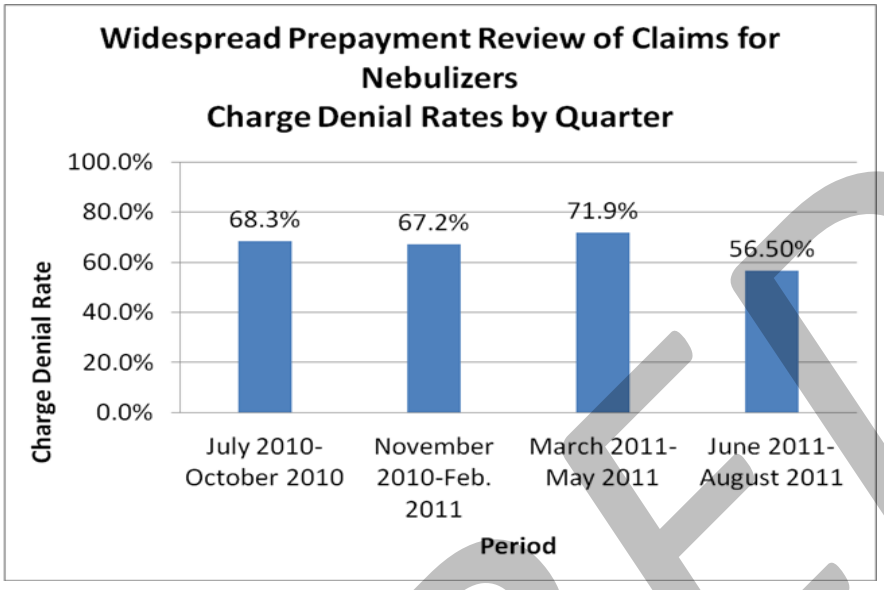
DME MAC A Medical Review continues to review Nebulizers, with Compressor, based on the results of previous quarterly findings. The previous quarterly findings covered the period of March 01, 2011 through May 31, 2011 and resulted in a Charge Denial Rate (CDR) of 71.9%.

Current Review Results

The DME MAC Jurisdiction A has recently completed a widespread prepayment review of claims for E0570 (Nebulizer, with Compressor). These findings cover the claim review period from June 1, 2011 through August 31, 2011.

The review involved prepayment complex medical review of 1,083 claims submitted by 535 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 496 (46%) of the claims. For the remaining 587 claims, 213 claims were allowed and 374 were denied/partially denied resulting in a claim denial rate of 64%. 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 56.5%.

Charge Denial Rate Historical Data



Primary Reasons for Denial

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

Clinical Documentation Issues:

- 71% of the denied claims were missing any clinical information to support medical necessity. No medical records of any sort were submitted.
- 25.1% of the denied claims had insufficient clinical documentation. The documentation submitted focused on other medical issues unrelated to nebulizers.

Detailed Written Order Issues:

- 4.8% of the denied claims were missing the detailed written order.

Proof of Delivery Issues:

- 12.7% of the denied claims were missing proof of delivery.

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

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

Claim Examples:

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

Example 1:

Received: Detailed MD order with legible signature and date, delivery ticket with legible signature.
Missing: Clinical documentation reflecting 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:

- *LCD for Nebulizers (L11499) and related 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 and July 01, 2011. **http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml**
- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements. **http://www.medicarenhic.com/dme/suppmandownload.shtml**
- *CERT Physician Letter - Nebulizers Monthly CERT Error examples* (January 2011, February 2011 and March 2011) **http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml**
- *Frequently Asked Questions* (search word nebulizer) **http://www.medicarenhic.com/faq_results.asp?categories=DME**

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

Historical Review Results

DME MAC A Medical Review continues to review Oxygen and Oxygen Equipment, based on the results of previous quarterly findings. The previous quarterly findings covered the period of July 01, 2011 through September 30, 2011and resulted in a 51.3% Charge Denial Rate (CDR).

Current Review Results

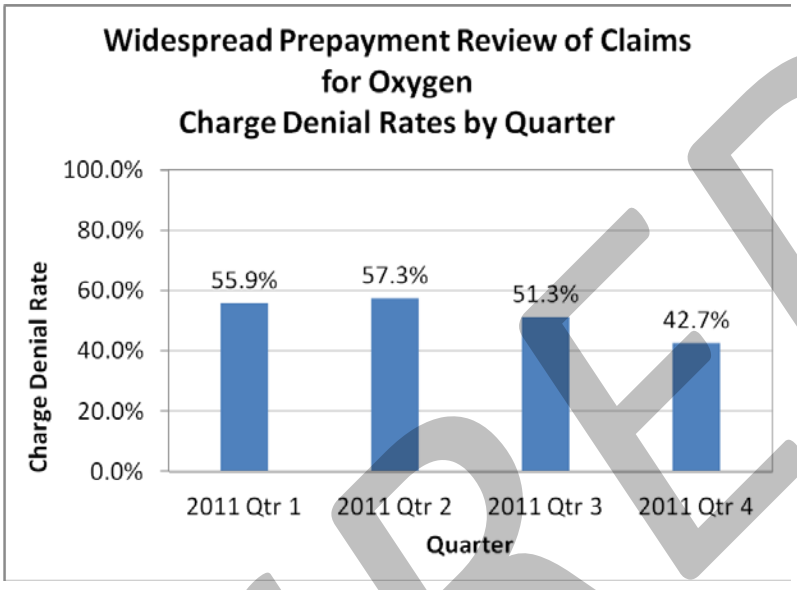
The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim process dates primarily from October 01, 2011 through December 31, 2011.

The review involved prepayment complex medical review of 935 claims submitted by 435 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 197 (21%) of the claims. For the remaining 738 claims, 422 claims were allowed and 316 were denied resulting in a claim denial rate of 33.8%. The total denied allowance amount (dollar amount of allowable

charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 42.7%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Missing Documentation: required Physician Visit per LCD L11468 (72%)

- 38% of the denied claims were missing treating physician visits - 90 days prior to Recertification CMN. (Initial oxygen).
- 27% of the denied claims were missing treating physician visits - 30 days prior to the Initial CMN. (Initial oxygen).
- 7% of the denied claims were missing treating physician visits both 30 days prior to the Initial CMN and within 90 day prior to the Recertification CMN. (Initial oxygen).

Missing Documentation : required Certificate of Medical Necessity per LCD L11468 (12%)

- 6% Initial CMN
- 3% Recertification CMN
- 3% Miscellaneous
  - Neither initial nor recertification CMNs
  - 5 year replacement; required recertification CMN
  - Clinical notes and written order only received

Clinical Documentation Issues: Medical Necessity could not be established per LCD L11468 (4%)

- Nocturnal testing did not meet Group 1 criteria. Concentrator billed. Less than 5 minutes recorded for saturation (desaturation) equal to or less 88%. Also missing physician initial visit.
- Recertification CMN was dated 24 months after initial CMN (Group 1); however, testing documentation received indicates patient saturation (desaturation) level met Group 2, initial coverage limited to 3 months before recertification.

Miscellaneous issues per documentation received: (2%)

- Services billed in error
- Services not rendered, equipment picked up
- Missing valid delivery ticket

Claim Examples

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

Per LCD L11468 - Visit requirements

> Patient must be seen and evaluated by treating physician within 30 days prior to the date of Initial Certification.
>
> For patients initially meeting Group I, the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of any Recertification.

Example 1: DOS 08/07/2011 code billed: E1390- initial Oxygen

Documentation received: Oxygen Verbal Order, Physician Written Order, Initial CMN, Recertification CMN, Delivery ticket, multiple supplier forms (including pickup form for portable).
Missing: Physician visit within 30 days prior to the Initial CMN dated 4/7/10 and corresponding physician visit for Recertification. No documentation submitted to validate oxygen saturation testing.

Example 2: DOS 04/12/2011 code billed: E1390- initial Oxygen

Documentation received: Physician Written Order, Testing documentation, Initial CMN, Recertification CMN, Delivery ticket.
Missing: Physician visit within 30 days prior to Initial CMN and physician visit within 90 days prior to Recertification CMN.

Example 3: DOS 09/27/2011 code billed: E1390 - replacement equipment

Documentation received: Documentation to support home oxygen therapy in 2006, New Initial CMN dated in 2011.
Missing: Delivery ticket to validate new equipment delivered and received by patient.

Next Step

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

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

Educational References

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

Suppliers are encouraged to review the following references:

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

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

- *January - November 2011 CERT Error Articles*
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

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

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

- *Results of Widespread Prepayment Review of Claims for Oxygen and Oxygen Equipment (HCPCS Codes E1390, E0431, and E0439)* (Posted November 4, 2011, March 25, 2011; November 5, 2010, Posted June 9, 2010, Posted August 26, 2011). **http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml**

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

Historical Review Results

DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices, HCPCS E0601, based on the results of the previous review findings. The previous quarterly findings covered claims reviewed from January 1, 2011 through June 30, 2011 and resulted in a 48.9% Charge Denial Rate (CDR).

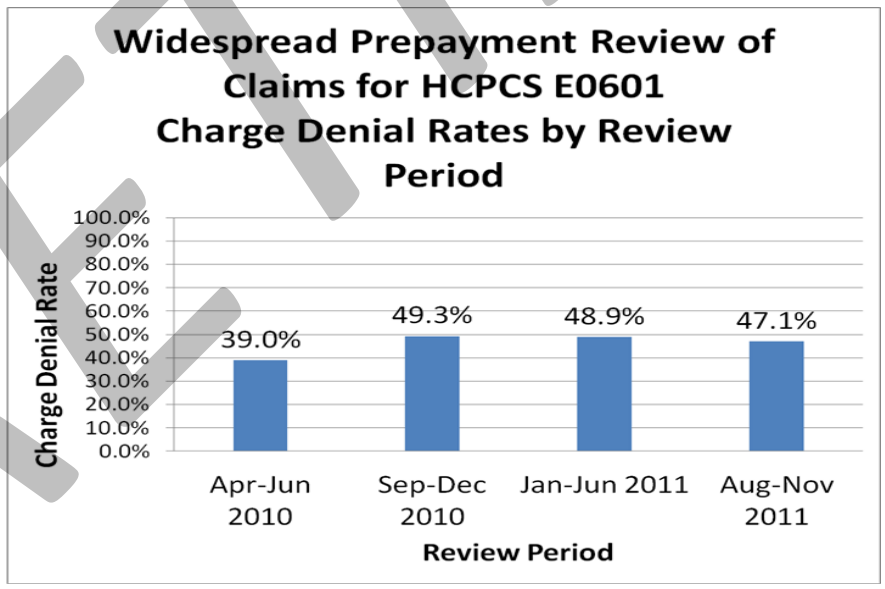
Current Review Results

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 reviewed from August 1, 2011 through November 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 1,007 claims submitted by 369 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 287 (29%) of the claims. Of the 720 claims for which responses were received, 244 claims were allowed and 476 were denied/partially denied. This resulted in a claim denial rate of 66%. 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 47.1%.

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

- 33.8% of the denied claims were missing required clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. Examples of no clinical documentation received include:
    - No Face to Face clinical evaluation from the beneficiary's medical record was submitted with claim.
    - No Face to Face clinical evaluation documented in the beneficiary's medical record within 31-91 days of initiation of therapy to allow for continuing coverage of the PAP device beyond the first 3 months. This document is meant to describe improvement in subjective symptoms of OSA and objective data related to compliance with PAP therapy.
    - No Face to Face clinical evaluation conducted by the treating physician found in the claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare.

- 8.8% 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. Examples of no clinical documentation received include:
    - Clinical documentation provided in the claim did not reflect the need for the care provided. No detailed narrative in the clinical documentation describing presenting symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores (the sleep hygiene inventory).
    - Face to Face clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued benefit from sleep therapy.
    - Insufficient clinical documentation found in Face to Face evaluations conducted by the treating physician in the claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare.

- 3.6% of the denied claims were missing the signature and/or date on the Face to Face clinical evaluation.
- 1% of the denied claims had illegible Face to Face documents.

Detailed Written Order issues

- 3.4% of the denied claims did not include the MD detailed order.
- Less than 1% of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- Less than 1% of the denied claims had detailed written orders that were illegible.
- Less than 1% of the denied claims had detailed written orders that were not dated by the treating physician.

Sleep Study Documentation Issues

- 9.9% of the denied claims did not include a copy of the original Medicare covered sleep study.
- 1.3% of the denied claims had sleep study documents that did not meet coverage criteria per the PAP LCD.
- 9.9% of the denied claims had no practitioner's signature on the Medicare approved sleep study interpretation per the PAP LCD.
- 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 submitted.

Proof of Delivery Documentation Issues

- 12% of the denied claims did not include proof of delivery.
- 1.7% of the denied claims had proof of delivery that did not include a beneficiary or designee signature when delivered directly to the beneficiary.
- Less than 1% of the denied claims did not include a date on the proof of delivery.
- Less than 1% of the denied claims did not include either the beneficiary's name and/or items billed.

Training Documentation issues

- 18% of the denied claims did not include evidence of training on the PAP device.

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 MD 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 MD 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 8/19/2011, 3/4/2011 and 7/2/2010
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/030411_E0601.pdf

- *DME MAC Jurisdiction A Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding 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

Standard Documentation Language for Local Coverage Determinations (GEN)

Many errors reported in DME MAC MR Reviews and CERT Audits arise from problems associated with submitted documentation. Discussions about documentation issues commonly focus on inadequate medical record information not created by the billing supplier. However, in addition to medical record information related errors, numerous errors are identified due to noncompliance with non-medical record documents. These errors can often be avoided by the supplier. LCDs are being revised to include more detailed information about documentation requirements.

An expanded and standardized DOCUMENTATION REQUIREMENTS section has been developed. It is written in a modular format to allow each policy to contain information relevant to that policy while not including material that does not apply. This revised section includes considerable detailed information about existing Medicare requirements that has historically been found in the DME MAC Supplier Manual or in CMS interpretive manuals. Suppliers are strongly encouraged to review this material and use it to ensure that the records created will meet the standards required to justify payment for the DMEPOS item(s) provided.

This article provides a complete listing of all of the documentation requirement modules. All modules may not be used in every LCD. For example, the CMN sections would not be included in the DOCUMENTATION REQUIREMENTS section of an LCD for an item that does not require a CMN.

*****IMPORTANT*****

Many policies contain coverage and documentation requirements that are unique to that specific policy. Such unique information is not included in this article. It is important that suppliers review the actual LCD to be sure to have all of the relevant information necessary applicable to the item(s) provided.

In several places you will see “placeholders” like “XXX” or “###”. Information specific to the policy will be inserted in these spots.

DOCUMENTATION REQUIREMENTS

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

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing Physician's name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.4) (OPTIONAL)

A detailed written order prior to delivery (WOPD) is required for XXX. The supplier must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 -5.9)

The **Indications and Limitations of Coverage and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Nonmedical Necessity Coverage and Payment Rules** section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED USE

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

1. Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories and supplies.
2. Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements This is deemed to be sufficient to document continued use for the base item, as well.
3. Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

CONTINUED MEDICAL NEED

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary's medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

REFILL DOCUMENTATION (PIM 5.2.5-6) (OPTIONAL)

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

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

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

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

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Information documenting that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date

PROOF OF DELIVERY (PIM 4.26, 5.8)

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as "Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. There are three methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service
3. Delivery of items to a nursing facility on behalf of the beneficiary

Method 1 - Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2 - Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Method 3 - Delivery to Nursing Facility on Behalf of a Beneficiary

When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

Regardless the method of delivery, for those beneficiaries that are residents of a nursing facility, information from the nursing facility showing that the item(s) delivered for the beneficiary's use were actually provided to and used by the beneficiary must be available upon request.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

GENERAL

CERTIFICATE OF MEDICAL NECESSITY (PIM 5.3) (OPTIONAL)

A Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for XXX is CMS Form ### (DME form ###). In addition to the order information that the physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the physician can enter the other details directly.

(Add specific DIF instructions as needed)

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

DME INFORMATION FORM (PIM 5.3) (OPTIONAL)

A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

(Add specific DIF instructions as needed)

REPAIR/REPLACEMENT (BPM Ch 15, §100.2)
Documentation Section

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

Refer to the specific LCD and DME MAC Supplier manual for additional information about documentation.

Suction Pumps Final Local Coverage Determination Released (SPE)

The Draft Suction Pumps Local Coverage Determination (LCD) released for comment in August 2011 has been finalized. The LCD, published March 1, 2012, will become effective for claims with dates of service on or after April 15, 2012.

The final LCD and a summary of the comments received with responses are available through the CMS Coverage Database and on each DME MAC web site.

Refer to the LCD for detailed information about coverage and documentation requirements for suction pumps. Refer to the related Policy Article for detailed information about statutory coverage requirements and coding guidelines for suction pumps.

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

2012 DME MAC Jurisdiction A Symposiums

DME MAC Symposiums - Knowledge is Key

The DME MAC Jurisdiction A Provider Outreach & Education Team is excited to announce that we will be hosting two Educational Symposiums offering a dynamic range of topics and speakers. In addition, attendees will have the opportunity to interact directly with various Medicare Contractors and State DMEPOS Associations in order to enhance their educational experience and get the most out of this excellent opportunity.

The Symposiums will be held on the following dates and locations:

Date	Location
April 04, 2012 (Wednesday)	BWI Airport Marriott 1743 West Nursery Road Linthicum, MD 21090
May 22, 2012 (Tuesday)	Four Points Sheraton Norwood Hotel & Conference Center 1125 Boston Providence Turnpike (Rte 1) Norwood, MA 02062

A Symposium Web page is available on the DME MAC A Web site, which can be accessed at:
http://www.medicarenhic.com/dme/symposium/Symposium_General_Information.shtml

This web page contains details and registration information. NHIC, Corp. DME MAC Jurisdiction A would like to extend this invitation to all interested Jurisdiction A suppliers. Registration will be taken on a first come, first served basis until maximum capacity has been reached for each location. Please forward this information to all applicable individuals and keep watching for more details!

We look forward to seeing you there!

1099-MISC Form Information (GEN)

NHIC, Corp. will mail all 1099 Forms for calendar year (CY) 2011 on January 30, 2012. Suppliers can expect 1099 Forms to arrive within 7-10 business days from the date of mailing.

Medicare suppliers and beneficiaries who are serviced by NHIC, Corp. will receive a single Part A, Part B, and Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC) combined by TIN from NHIC for CY 2011.

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

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

Common Question/Concerns:

What should I do if I did not receive a 1099?
Verify that you have received greater than $600 in payments and that your mailing address is current at the National Supplier Clearinghouse (NSC). If the answer is yes to both of these questions, contact the NHIC, Corp. Customer Service Department at 1-866-590-6731.

What address will my 1099 be mailed to?
1099's are mailed to the address on record with the NSC.

My mailing address is not current at the National Supplier Clearinghouse.
A new 855 form will need to be submitted to the NSC. Once the address is updated, contact the NHIC, Corp. Customer Service Department at 1-866-590-6731 and request that a duplicate 1099 be issued.

My 1099 has been misplaced, how can I obtain a duplicate?
Send a written request to the NHIC, Corp. Written Inquiries Department address above or contact the NHIC, Corp. Customer Service Department at 1-866-590-6731.

How was the figure reported in Box 6 (Medical and health care payments) calculated?
The 1099 amount is calculated by totaling the amount of money paid to the supplier during the reporting year (this includes claim payments that were offset on established account receivables).

I have verified my records and do not agree with the amount reported on the 1099.
Send a letter to the NHIC, Corp. Written Inquiries Department detailing your concern.

A 1099-Misc was received but I am tax-exempt.
NHIC, Corp is required to issue 1099-MISC form in accordance with the Internal Revenue Code. It is the responsibility of the supplier to contact the IRS pertaining to tax status and reporting requirements.

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

Ask-the-Contractor Teleconference (ACT) Q&A - December 20, 2011 (GEN)

The DME MAC Jurisdiction A quarterly ACT call was conducted Tuesday, December 20, 2011 as a teleconference/webinar and was based on recent updates and hot topics. 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: **Can Medicare educate ordering physicians of their responsibility to provide copies of patient's medical records to the supplier?**
A1: NHIC has been working with the A/B MACs to ensure physicians are educated on the need for providing comprehensive physician notes/medical records to DMEPOS suppliers for items/services they order for their Medicare beneficiaries.

Q2: **What is being done to further educate doctors about what needs to be documented to qualify their patients for DME?**
A2: The Medical Directors of all four DME MAC jurisdictions continue to develop "Dear Physician" articles to assist suppliers in obtaining the required information.

Q3: **Does the supplier hold any responsibility in educating the ordering physician on documentation requirements?**
A3: Yes. The supplier does carry a responsibility to inform and educate the ordering physicians of the Medicare requirements for the item they are ordering.

Q4: **How old is too old for patient documentation to be submitted for DME supplies?**
A4: There may be some provisions as to how old documentation can be and this would usually be addressed in the specified LCD/medical policy. Documentation must be pertinent to the item/issue at hand. Also, the documentation must reflect the

patient's current need and/or results. Therefore, documentation can be dated as older; however, it could be viewed as part of the criteria to meet the medical need if it still reflects the patients existing need and/or condition.

Q5: Why is Medicare denying claims at the appeals level because the documentation from physician is not within the last six months?

A5: For most DMEPOS items, there is no specific time frame requirement for the receipt of documentation; however, some items such as PMDs have set requirements noted in the LCD/Medical Policy. In addition, keep in mind that documentation is based upon a patient's condition and need. If the condition is of a more serious nature and would require a physician to follow-up with the patient more often, then documentation would be needed to reflect the physician visit. For many items, Medicare coverage requires that continued use must be assessed and documented by the treating physician. Rental items such as oxygen, nebulizers, CPAP, wheelchairs, and hospital beds and recurring supplies such as glucose test strips, urological supplies, and ostomy supplies must be periodically justified in the medical record. Ongoing need for and use of the item must be documented in the patient's medical record in a detailed narrative entry in order for Medicare to continue reimbursement for the equipment or supplies. In these instances, the treating physicians or their staff should regularly review the use of medical equipment and supplies by their patients. This review should be no different than a review of the continued need for medication or other treatments. If this documentation is not available, the claim will be denied. Several Physician Letters were developed to assist DMEPOS suppliers in obtaining the necessary documentation and are available on our web site at: **http://www.medicarenhic.com/dme/phy_letters.shtml**

Q6: For a PAP device, what is specifically required in the face-to-face documentation?

A6: For the initial evaluation, the report would commonly document pertinent information about the following elements, but may include other details. Each element may not need to be addressed in every evaluation.

History

- Signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches
- Duration of symptoms
- Validated sleep hygiene inventory such as the Epworth Sleepiness Scale

Physical Exam

- Focused cardiopulmonary and upper airway system evaluation
- Neck circumference
- Body mass index (BMI)

Q7: What can I do if I did not give the patient an ABN and the claim denied?

A7: If the item is a rental item, you can obtain an ABN for dates of service on future rental claims for the item/service that you expect Medicare to deny. You cannot use the ABN for claims that have been previously billed because the ABN was not obtained prior to the first rental month claim.

Q8: How do you verify that a patient is not receiving diabetic supplies from another supplier before you provide supplies to them?

A8: If the patient is not aware that they are receiving diabetic supplies from another supplier, you may call a Customer Service Representative (CSR) to verify that same/similar equipment is not currently being provided. When you call the CSR line, you must have the patient either on a 3-way call or in your office in order for the CSR to speak with the patient and get their approval to release the information. Once this has been completed you will be able to verify if there is same/similar equipment is on file.

Q9: How long is a prescription valid for?

A9: You should first check the specific Local Coverage Determination (LCD) for the items being order to verify if there is a specified timeframe noted. Some policies may require a prescription every 6 months, every year, or on a regular basis. If there is a specified timeframe it will be noted in the Documentation Requirements section of the LCD. In addition, keep in mind that a new prescription is required if there is a change in the accessory, supply, or drug, when an item is replaced, or if the beneficiary is changing suppliers. **Note:** *State laws may have more stringent requirements which would also have to be followed.* For additional information, you may refer to Chapter 10 of the *DME MAC A Supplier Manual* on our web site at: **http://www.medicarenhic.com/dme/suppmandownload.shtml**

Q10: When does the patient sign an ABN?

A10: The patient (or legal representative if one is appointed) should sign and date the ABN prior to the items/services being furnished. Additional ABN information is available in Chapter 10 of the *DME MAC A Supplier Manual* at **http://www.medicarenhic.com/dme/suppmandownload.shtml**. An ABN tutorial is also available on our web site at **http://www.medicarenhic.com/dme/dme-eduonline.shtml#tutorials**

Q11: Are there any changes to the modifiers used for claim submission?

A11: No. There haven't been any recent additions or changes to modifiers. Modifier changes are typically announced with the release of the January HCPCS update. For additional guidance, a modifier table is available on our web site at: **http://www.medicarenhic.com/dme/medical_review/mr_index.shtml#hcpcs**

Q12: Is a semi electric hospital bed only covered if someone has a respiratory condition?

A12: No. A semi-electric hospital bed (E0260, E0261, E0294, E0295, and E0329) is covered if the patient meets one of the following criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position:

1. The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
2. The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, or
4. The patient requires traction equipment, which can only be attached to a hospital bed.

Additional coverage details are available on the DME MAC A Web site in the LCD for Hospital Beds and Accessories.

Q13: Why can't I find the LCD and modifiers for hand, finger, and elbow orthopedic support items?

A13: Currently, there is not an LCD/medical policy specific to upper limb orthotics. However, coverage may be available and will be based on individual medical need. The required modifiers are LT (left side) and/or RT (right side). If providing the same HCPCS code bilaterally the items should be billed on one claim line with the LTRT modifiers added to the HCPCS code and 2 units of service.

Q14: Can a supplier provide and bill for a 3 month supply of A7032 replacements cushions at the same time as the initial setup?

A14: Medicare allows suppliers to deliver a three month quantity of CPAP supplies. However, replacement supplies should not be delivered until required by the beneficiary for use.

Q15: If the physician wants to change item/HCPCS within the same LCD category (ex. E0277 to E0373), is a new written order needed?

A15: Yes. A new written order is needed when:

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

Q16: Discuss repairs of equipment not yet at the 5 yr RUL. Does Medicare pay for repairs to equipment that has not yet met the 5 year reasonable useful lifetime (RUL)?

A16: Repairs to beneficiary owned equipment are considered for coverage if they are necessary for proper functioning of the equipment. Medicare does cover repair, up to the cost of replacement, for medically necessary equipment owned by the beneficiary. Repairs to rental equipment (including capped rentals that are still in the rental periods) are not separately billable. Repairs for previously denied equipment will not be covered.

The information needed on the claim is a statement that this service is for repairs to beneficiary owned equipment in addition to the date of purchase, the HCPCS code, and a description of the beneficiary owned equipment. Example: "RPRs to PT owned PRIDE JAZZY610 K0011 PWC PUR 41603" (51 characters) All other required supporting medical documentation should be retained in provider files.

When billing miscellaneous codes such as K0108 the following information is required:

- If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108.
- A description of the item, and the brand name, make/model and part number (use abbreviations when needed). You can abbreviate the brand name by using just the first 5 letters if needed. Do not abbreviate the model/part number.

  Example: "TOGGLE SWITCH.MFR PRIDE MD#FRMASMB272 REPLCMNT" (46 characters) this could be further abbreviated to "RPL toggle MFR PRIDE MD FRMASMB272" (34 characters)

Providers will need to utilize the NTE fields (2300 and 2400) to submit all information pertinent to claims filed. The note segment is limited to 80 characters at the claim level and each line level, so providers should not include any wording that does not relate to the items and services being billed. If claims that require additional information for adjudication are submitted with nothing documented in the NTE fields (e.g. repairs), these claims will be denied.

Q17: How are automated claims set up to recognize competitive bid contract suppliers?
A17: System edits are set up for the product categories and specific MSAs included in the Competitive Bidding Program. Competitive bidding contract winners are flagged in the system to ensure proper payment.

Q18: Can we expect the Enteral Nutrition LCD/medical policy to be updated with the "continued use/continued need" language?
A18: The Medical Directors are currently considering adding this information to all applicable LCDs, and will likely be incorporated in the near future.

Q19: Are we still allowed to use sleep study results to qualify patients for oxygen?
A19: No. The patient must be in a chronic stable state during the oxygen testing. They would have to receive the PAP device first and be treated for sleep apnea which must be under control before they could qualify for oxygen.

Q20: What information does a supplier need in order to accurately bill for a break in medical need?
A20: Please refer the article titled, "Electronic Submission of Claims Involving a Break in Service" available at:
http://www.medicarenhic.com/dme/articles/091906_bis.pdf

Q21: How do repairs fit in to competitive bidding?
A21: Please refer to the Competitive Bidding Program Repairs and Replacements Fact Sheet for details on repairs and replacements under the competitive bid program available at:
http://www.cms.gov/MLNProducts/downloads/DME_Repair_Replacement_Factsheet_ICN905283.pdf

Q22: If you are on the list for revalidation letters gone out by CMS, but did not receive a letter, how do you get the information?
A22: You should notify the National Supplier Clearinghouse (NSC) by calling 866-238-9652. In addition, a sample letter is available at **http://www.cms.gov/MedicareProviderSupEnroll/Downloads/NSC_RevalidationLetter.pdf** and can be used as a reference to know what type of information is included in the letter.

Q23: Can you provide details about competitive bidding such as when and how to participate?
A23: Detailed program information is available on the Competitive Bidding Implementation Contractor (CBIC) Web site at:
http://dmecompetitivebid.com and also the CMS Web site at:
http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp. Each web site has helpful information related to timelines, important dates, educational information, quarterly updates and much more.

Q24: What is the status of the "K" code and Kalypto wound suction device?
A24: New HCPCS codes have been created to describe wound suction pumps and the associated dressing sets. These new K-codes were effective for claims with dates of service on or after July 01, 2011. An article was posted to the DME MAC Web site on July 08, 2011 and is available at:
http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/070811_kcode.pdf

Note: Wound suction is provided with an integrated system of components. This system contains a pump (K0743) and dressing sets (K0744-K0746). It does not include a separate collection canister (A7000), a defining component of Negative

Pressure Wound Therapy (NPWT). Instead, exudate is retained in the dressing materials. Therefore, wound suction systems are not classified as NPWT systems. These codes will be added to the Suction Pump LCD in a future revision to that policy.

Q25: What kind of chart documentation is being looked for on Nebulizers?

A25: For Nebulizers to be covered by Medicare, the patient's medical record must contain sufficient information about the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The ordering physician is responsible for the following:

- Detailed written order with the following:
  - Patient Name
  - The description of item to be dispensed
  - The type of solution
  - Administration instructions:
    - Amount of Solution
    - Frequency of Use
  - The ordering physician's legible signature
  - The date of the ordering physician's signature
    Note: A new order is required every 12 months for ALL Inhalation Drugs (even if the prescription has not changed).
- Clinical records that document the treating physician's oversight, continued medical necessity, and the patient's compliance to the treating physician's treatment plan for the aerosol treatments. In other words, medical records reflecting the reasonable and necessary need for nebulizer equipment
- A payable diagnosis

For complete coverage information, you may access the Nebulizers Local Coverage Determination (LCD) L11499 at: **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**. In addition, a letter addressed to the treating physician has been developed as a result of CERT findings that may be used to assist DMEPOS suppliers in receiving the necessary documentation and is available at:
http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_nebulizers.pdf

Q26: Is DME covered for place of service (POS) 32? The CMS Internet Only Manual, Pub. 100-04 states it is Non Facility payment rate but I am being told it is not covered in any facility.

A26: No. DME is not covered in POS 32 The facility and non-facility designations in the CMS *Claims Processing Manual* are specific to Medicare payment for services on the Physician Fee Schedule, not the DMEPOS fee schedule.

Q27: Are you able to provide full electric hospital beds or only semi-electric since the recent elimination of least costly alternative (LCA).

A27: Yes. You may still provide full electric beds; however, in order to ensure the proper liability denial for the full electric bed the claim must be billed as an upgrade with the appropriate upgrade modifiers. Additional information is available on the DME MAC A Web site in an article titled, "*Use of Upgrade Modifiers*" (**http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/121610_mod.pdf**).

Q28: What are the coverage requirements for transport chairs? Is there an LCD?

A28: Currently, transport chair coverage is not included in any existing LCD/medical policy; however, you may reference the Mobility Assistive Equipment Algorithm. Medical need is very similar to that of a manual wheelchair but instead of the patient being able to self-propel, they must have a caregiver who is available, willing, and able to transport the patient in the chair.

Q29: Where can you go to get status of your Medicare payment?

A29: The following options are available for claim status:

- **Interactive Voice Response (IVR) System** - A toll-free automated telephone self service tool. Providers can obtain information such as claim status, patient eligibility, Certificate of Medical Necessity (CMN) status information, pricing and appeals information, as well as some general information.
- **ViPS Provider Inquiry System** - Provides access to instant claim status updates and "on the spot" beneficiary eligibility. This is also referred to as CSI (Claims Status Inquiry).
- **Provider Services Portal (PSP)** - A web site tool that can be used by NHIC DME MAC Suppliers. The PSP offers the DME MAC Jurisdiction A supplier community an alternative to the IVR or Customer Service Toll Free line.

Q30: Do suppliers need to take any action to revalidate on their own or do we need to wait to hear from the NSC?
A30: Suppliers should wait to receive the revalidation request letter from the NSC prior to taking any action.

Q31: If the physician orders O2 but does not include all the required documentation in the notes from the initial visit how should this be handled? Would the patient need another face-to-face visit?
A31: If the patient didn't qualify because all of the required documentation wasn't provided or the physician didn't document properly, then a follow-up face to face would be required resulting in the need for the physician to adequately document what is needed.

Q32: We are moving from one location to another in the same city. What is the process with regard to updating our information?
A32: You must contact the NSC to complete a change of information. Supplier Standard #2 requires suppliers to notify the NSC of any change to the information provided on the CMS-855S or as reported in PECOS within 30 days. Therefore, if you have added or stopped providing a specialty, product or service; moved to a new location; or made changes to your ownership, you must notify the NSC. Failure to do so may result in the revocation of your billing privileges and/or overpayments. Additional information is available on the NSC Web site at: **http://www.palmettogba.com/nsc**

Q33: Are HH Agencies included in the enrollment application fee for institutional providers?
A33: The application fee is to be imposed on 'institutional provider' that are newly-enrolling, re-enrolling/re-validating or adding a new practice location for applications received on and after Friday, March 25, 2011. CMS has defined 'institutional provider' to mean any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application. Since Home Health Agencies are required to complete the CMS-855A Enrollment Application they are subject to the application fee as noted above.

Q34: What elements listed in the O&P Dear Physician Letters are the most important to obtain that can help down the road in an audit?
A34: All items outlined in the letter are items that are reviewed in a claim review/audit. It is important that the documentation that you are obtaining substantiates the medical need for the item you are providing. Documentation section highlights important details as well.

Q35: Does a patient have to have a respiratory diagnosis for a hospital bed to be covered?
A35: Refer to Q12 of this document. This policy is not diagnosis driven meaning there are not specific diagnosis codes listed in the LCD that indicate coverage. Coverage is based on the specified criteria listed in the LCD.

Q36: Regarding glasses after cataract surgery, why do we use the date of dispense as the date of service?
A36: Claims submitted to the DME MAC require that the date of service is the date you dispensed the item to the Medicare patient.

Q37: If a Medicare patient comes to the supplier with an order/script that was written 10 months prior, is that a valid script? Is there an expiration timeline?
A37: Currently, there is no specific expiration timeline for orders. Generally speaking, if an order was written more than three months ago medical need may be questionable in terms of whether or not the item is still reasonable and necessary for that patient. Additional information may be required to support why the order was written that many months prior to the patient receiving the item.

Q38: If the patient is in a skilled nursing facility (SNF) but is paying privately to stay there, can you still bill Medicare as a POS 12 for home?
A38: No. The claim must be billed with a POS of 31 for a SNF regardless if it is self-pay stay or not. DME is not payable in a SNF; however after Part A has stopped making payments (typically after the first 100 days) Medicare will pay for some items such as enteral/parenteral nutrition, ostomy supplies, urological suppliers, and a few other limited exceptions.

Q39: When are attestation statements necessary?
A39: In some cases, a medical record or entry omits a legible identifier requiring the author to attest to the authenticity of the record. To be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Attestation

statements are not valid for orders or CMNs where the author's signature or initials are not authenticated. Note: An attestation statement cannot be used as an addendum to the medical record. An overview of the key points of CMS' signature requirements, including signature logs and attestation statements, can also be found in MLN Matters article MM6698 at: **http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf**

Q40: Why does the CGS DME MAC contractor web site have a different revision effective date for the heating pad LCD than the other DME MACs?

A40: The revision date listed on the CGS Web site and mentioned during the recent ACT call did not have to do anything with a policy or coverage change. CGS recently adopted a new business name which resulted in the need for them to update the LCD information accordingly.

Q41: Are there any exceptions to the Medicare timely filing rules?

A41: Currently, the following four exceptions apply to timely filing which may permit an extension:

- Administrative error
- Retroactive Medicare entitlement
- Retroactive Medicare entitlement involving state Medicaid Agencies
- Retroactive Disenrollment from a Medicare Advantage Plan or a Program All-inclusive Care of Elderly (PACE) provider organization.

Additional details are available in MLN Matters article MM7270 at:
http://www.cms.gov/MLNMattersArticles/downloads/MM7270.pdf

Q42: If we do not receive the written order from the physician until after the item is already dispensed should the initial date on the CMN match the date on the order?

A42: The initial date on the CMN is based on the initial date of need for the item. If a supplier dispenses an item based on a verbal order the supplier must maintain written documentation of that verbal order and must obtain the detailed written order prior to claim submission.

Q43: What if we have an issue getting the written order from the physician after we have already dispensed an item based on a verbal order?

A43: If a supplier does not have a faxed, photocopied, electronic or pen and ink signed detailed written order in their records before they submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. Several Dear Physician Letters are available that were developed to assist suppliers in obtaining the proper documentation from the ordering physician and are available at: **http://www.medicarenhic.com/dme/phy_letters.shtml**. Additional information relating to orders is also available in the CMS *Medicare Program Integrity Manual*, Pub. 100-08, Chapter 5.

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.

Fourth Quarter 2011 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for October through December 2011 are provided in the following table.

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

Top Ten Claims Submission Errors	Number Received	Reason For Error
C172 - Invalid Procedure Code and/or Modifier	124,557	The procedure code, modifier, or procedure code and modifier combination is invalid.
C044 - Subscriber Primary ID Invalid	28,620	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
C008 - EIN/SSN Not On File w/ National Provider Identifier (NPI)	20,258	The Tax ID (Employer Identification Number/Social Security Number) that was submitted does not match what is on file with the NPPES or the National Supplier Clearinghouse (NSC).
C171 - Capped Rental - Modifier Missing	18,671	The item (whether for purchase or rental) is classified as a capped rental item (or possibly a pen pump item), and the required KH, KI, or KJ modifier (whichever is appropriate) was not submitted.
C003 - Billing NPI Not Found on Crosswalk	18,610	There is no link between the NPI that was submitted and a PTAN/NSC.
B108 - Billing provider not authorized for submitter	18,233	The NPI submitted is not linked to the Submitter ID under which the claim file was sent.
C095 - Diagnosis Code Invalid - Pointer 1	16,809	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
C180 - Service Date Greater than Receipt Date	11,746	The service start/from date is greater than the date this claim was received.
C179 - Service From/To Dates Not Equal	11,722	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.
C183 - Required Note Missing	10,116	The narrative information is missing. The procedure code submitted requires narrative information.

Fourth Quarter 2011 - 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 fourth quarter of 2011. Claims denied in this manner are considered to be unprocessable and have no appeal rights. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

The below table reflects those claims that were accepted by the system and processed, however, were denied with a return/reject action code, which could have been prevented upon proper completion of claim information. This table represents the top errors for claims processed from October through December 2011.

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form (or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	33,421
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.	9,658
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.	2,840
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.	2,438
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).	1,722
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	1,694
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.	998
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.	904
CO 16 N51 - Electronic interchange agreement not on file for provider/submitter.	The PTAN/NSC on file is not eligible to submit electronic claims.	737
CO 16 N257 Missing / incomplete / invalid billing provider/supplier primary identifier.	**Item 33** - Provider Transaction Access Number (PTAN) number submitted in error. Must submit National Provider Identifier (NPI).	516

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/QuarterlyProviderUpdates/**. CMS encourages you to bookmark this Web site and visit it often for this valuable information.

Supplier Manual News (GEN)

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

Updates/Corrections Made:

In December of 2011 chapters 1, 2, 4, 8, 9, 10 and 12 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.

Provider Services Portal (PSP) - NHIC, Corp. has been receiving requests to have a program that DME MAC Jurisdiction A suppliers can use to easily access beneficiary eligibility and claims information over the internet. We are pleased to announce that the PSP is now available for open enrollment! If you are interested in becoming a PSP participant visit:
http://www.medicarenhic.com/dme/dme_psphome_index.shtml

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

781-741-3950

Claims Submissions

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

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

Written Inquiries

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

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

Note: *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

March 2012
Number 23

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
Hingham, MA 02043