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

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General Information

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

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Addition of Digital Document Repository to Provider Enrollment Chain and Ownership System (PECOS) (SE1230) (GEN)

MLN Matters® Number: SE1230
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 submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

STOP - Impact to You

This article informs Medicare contractors about the changes and enhancements to the online version of the Provider Enrollment, Chain, and Ownership System (Internet-based PECOS). The changes allow physicians, other providers, and suppliers to digitally upload their PECOS supporting documents and submit them electronically with their enrollment application. A "*Digital Document Repository (DDR) How to Guide*" is available at **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DigitalDocumentRepository-HowToGuide.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

GO - What You Need to Do Go Light

Make sure that your provider enrollment staff is aware of these changes. See the Background and Additional Information Sections of this article for further details regarding these changes.

Note: *Providers/Suppliers are not required to utilize the Digital Document Repository (DDR) process and still have the option to mail their supporting documents to their MACs.*

Background

CMS has updated Internet-based PECOS to allow all providers/suppliers the ability to submit electronic copies of supporting documentation to a DDR. Prior to this enhancement, providers/suppliers were required to mail copies of all supporting documentation to their MAC.

The DDR will be accessible by providers/suppliers via Internet-based PECOS during the application submission process. The DDR will apply to any documents required to be submitted as part of the Medicare Enrollment application and requests from the MACs for additional documentation that may be essential to completely process the provider/supplier's enrollment application. Examples include, but are not limited to:

- Medical Licenses/Certifications;
- Final Adverse Legal Action documentation;
- Internal Revenue Service (IRS) tax documents;
- Accreditation documentation;
- Voided Check/Account Verification (for Electronic Funds Transfer (EFT));
- National Provider Identifier (NPI) Confirmation Letters;
- Pay.gov receipts;
- Provider Agreements; and
- CMS-460 Participation Agreement Forms.

Internet-based PECOS users will have the ability to upload all supporting documentation for any enrollment application that can be submitted via Internet-based PECOS, including new enrollment applications, Changes of Information (COI) applications, and revalidation applications. Uploaded documents must be in a PDF or TIFF file format, and be equal to or less than 10MB per file. Documents can only be uploaded for an application that has not yet been submitted for processing, or if the application has been returned for corrections. Once the application has been submitted for processing, the provider/supplier will not be able to attach any additional documents unless the application is Denied, Rejected, or Returned for Corrections by the MAC; or the application is Approved and a new application is submitted (e.g., COI). Users who wish to submit an application for the sole purpose of updating documentation would submit a COI, and update the documents associated with the enrollment record. Users will also have the ability to classify documents that are uploaded based on the document type and to upload more than one document of a particular type (e.g., uploading of multiple documents with the type "W-2 for Managing Employee" for multiple W-2s for managing employees). Users will have the ability to add or delete previously submitted documents as part of a COI application submission and view/print any supporting documentation that was previously submitted and is currently associated with an enrollment record.

Additional Information

To download the "*Digital Document Repository (DDR) How to Guide*" on how to use the new DDR functionality, please refer to **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/DigitalDocumentRepository-HowToGuide.pdf** on the CMS website.

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

Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, Updated Manual Instructions (MM7821) (GEN)

MLN Matters® Number: MM7821
Related CR Release Date: June 1, 2012
Related CR Transmittal #: R2480CP

Related Change Request (CR) #: CR 7821
Effective Date: September 4, 2012
Implementation Date: September 4, 2012

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 7821 which clarifies the currently published instructions on Advance Beneficiary Notice of Noncoverage (ABN) use in the "*Medicare Claims Processing Manual*" (Chapter 30, Section 50). Make sure that your billing staff is aware of these ABN policy updates and clarifications that are summarized in this article.

Background

ABNs are issued by providers and suppliers to inform beneficiaries in Original Medicare about possible charges for items or services that are not covered by Medicare. Issuance of the ABN is required in certain situations when limitation of liability (LOL) applies. You may review that information in the *Social Security Act* (Section 1879; see **http://www.ssa.gov/OP_Home/ssact/title18/1879.htm**). In 2008 CMS revised the notice and its instructions to streamline and simplify the notice process.

Change Request (CR) 7821 revises the current manual instructions on ABN use in the "*Medicare Claims Processing Manual*", Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)). The revised Chapter 30, Section 50 is included as an attachment to CR7821. **The last page of this article contains a "Quick Glance Guide" from the revised manual section, that may help you and your staff comply with ABN issuance requirements.**

Key Points from the Updated Chapter 30 Section 50

General Information

Section 50 of the "*Medicare Claims Processing Manual*" establishes the standards for use by providers and suppliers (including laboratories) in implementing the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, formerly the "Advance Beneficiary Notice."

Since March 1, 2009, the ABN-G (general) and ABN-L (laboratory) are no longer valid notices and have been replaced with the ABN.

ABN Scope

The ABN is an Office of Management and Budget (OMB) approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and certain care provided under Part A (hospice and religious non-medical healthcare institutes only).

The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The ABN is used to fulfill both mandatory and voluntary notice functions.

Skilled Nursing Facilities (SNFs) issue the ABN for Part B services only. The Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form 10055, is issued for Part A SNF items and services.

Home Health Agencies (HHAs) do not issue the ABN. HHAs issue the Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296.

Mandatory ABN Uses

The following provisions of the *Social Security Act* necessitate delivery of the ABN:

- Section1862(a)(1) of the *Social Security Act* (not reasonable and necessary); **http://www.ssa.gov/OP_Home/ssact/title18/1862.htm**;
- Section 1834(a)(17)(B) of the *Social Security Act* (violation of the prohibition on unsolicited telephone contacts); **http://www.ssa.gov/OP_Home/ssact/title18/1834.htm**;
- Section 1834(j)(1) of the *Social Security Act* (medical equipment and supplies supplier number requirements not met),
- Section 1834(a)(15) of the *Social Security Act* (medical equipment and/or supplies denied in advance),
- Section 1862(a)(9) of the *Social Security Act* (custodial care); (**http://www.ssa.gov/OP_Home/ssact/title18/1862.htm**),
- Section 1879(g)(2) of the *Social Security Act* (hospice patient who is not terminally ill); see **http://www.ssa.gov/OP_Home/ssact/title18/1879.htm** on the Internet.

Expanded Mandatory ABN use in 2011

In addition, delivery of an ABN is mandatory under 42 CFR §414.408(e)(3)(ii) (**http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl** t) when a noncontract supplier furnishes an item included in the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) for a Competitive Bidding Area (CBA) unless the beneficiary has signed an ABN. Although all other denial reasons triggering mandatory use of the ABN are found in Section 1879 of the Social Security Act, in this situation, Section 1847(b)(5)(D) (**http://www.ssa.gov/OP_Home/ssact/title18/1847.htm**) of the *Social Security Act* permits use of the ABN with respect to these items and services.

The Affordable Care Act, P.L. 111-148, section 4103(d)(1)(C) added a new subparagraph (P) to 1862(a)(1) of the Act. Per section 1862(a)(1)(P), Medicare covered personalized prevention plan services (as defined in section **1861(hhh)(1))** that are performed more frequently than covered are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The limitation of liability (LOL) provisions of section1879 apply to this new subparagraph; thus, providers must issue an ABN prior to providing a preventative service that is usually covered by Medicare but will not be covered in this instance because frequency limitations have been exceeded.

Voluntary ABN Uses

ABN issuance is not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or most care that fails to meet a technical benefit requirement (i.e. lacks required certification). However, the ABN can be issued voluntarily.

The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation. When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice. The provider or supplier is not required to adhere to the issuance guidelines for the mandatory notice (as set forth below) when using the ABN for voluntary notification.

Note: *Certain DME items/services that fail to meet a technical requirement may require an ABN as outlined in the mandatory use section above.*

ABN Triggering Events

Notifiers are required to issue the ABN when an item or service is expected to be denied based on one of the provisions in the Mandatory Use section above. This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as "**triggering events**."

A. Initiations

An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment. If a notifier believes that certain otherwise covered items or services will be noncovered (e.g. not reasonable and necessary) at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.

Example: Mrs. S. asks her physician for an EKG because her sister was recently diagnosed with atrial fibrillation. Mrs. S. has no diagnosis that warrants medical necessity of an EKG but insists on having an EKG even if she has to pay out of pocket for it. The physician's office personnel issue an ABN to Mrs. S. before the EKG is done.

B. Reductions

A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.). The ABN is not issued every time an item or service is reduced. But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this noncovered care.

Example: Mr. T is receiving outpatient physical therapy five days a week, and after meeting several goals, therapy is reduced to three days per week. Mr. T wants to achieve a higher level of proficiency in performing goal related activities and wants to continue with therapy 5 days a week. He is willing to take financial responsibility for the costs of the 2 days of therapy per week that are no longer medically reasonable and necessary. An ABN would be issued prior to providing the additional days of therapy weekly.

C. Terminations

A termination is the discontinuation of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

Example: Ms. X has been receiving covered outpatient speech therapy services, has met her treatment goals, and has been given speech exercises to do at home that do not require therapist intervention. Ms. X wants her speech therapist to continue to work with her even though continued therapy is not medically reasonable or necessary. Ms. X is issued an ABN prior to her speech therapist resuming therapy that is no longer considered medically reasonable and necessary.

Completing the ABN

The ABN and step by step instructions for notice completion are posted on the CMS website at **http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html** on the CMS website. Notifiers must follow the instructions posted on the CMS website to construct a valid notice.

Retention Requirements Retention periods for the ABN are five years from discharge/completion of delivery of care when there are no other applicable requirements under State law. Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice. Electronic retention of the signed paper document is acceptable. Notifiers may scan the signed paper or "wet" version of the ABN for electronic medical record retention and if desired, give the paper copy to the beneficiary.

Clarification of Period of Effectiveness/ Repetitive or Continuous Noncovered Care

An ABN can remain effective for up to one year. Notifiers may give a beneficiary a single ABN describing an extended or repetitive course of noncovered treatment provided that the ABN lists all items and services that the notifier believes Medicare will not cover. If applicable, the ABN must also specify the duration of the period of treatment. If there is any change in care from what is described on

the ABN within the 1-year period, a new ABN must be given. If during the course of treatment additional noncovered items or services are needed, the notifier must give the beneficiary another ABN. The limit for use of a single ABN for an extended course of treatment is one year. A new ABN is required when the specified treatment extends beyond one year.

If a beneficiary is receiving repetitive non-covered care, but the provider or supplier failed to issue an ABN before the first or the first few episodes of care were provided, the ABN may be issued at any time during the course of treatment. However, if the ABN is issued after repetitive treatment has been initiated; the ABN cannot be retroactively dated or used to shift liability to the beneficiary for care that had been provided before ABN issuance.

Electronic Issuance of the ABN

Electronic issuance of ABNs is not prohibited. If a provider elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what s/he prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed ABN to keep for his/her own records. Electronic retention of the signed ABN is permitted.

ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Notifiers must give an ABN before a beneficiary receives a Medicare covered item containing upgrade components that are not medically reasonable and necessary and not paid for by the supplier. For example, an ABN must be issued when a notifier expects that Medicare will not pay for additional parts or features of a usually covered item because those parts and/or features are not medically reasonable and necessary.

ABNs for Items Listed in a DMEPOS Competitive Bidding Program

The *Social Security Act* (Section 1862 (a)(17)(**http://www.ssa.gov/OP_Home/ssact/title18/1862.htm**) excludes Medicare payment for Competitive Bidding Program (CBP) items/ services that are provided by a non-contract supplier in a Competitive Bidding Area (CBA) except in special circumstances. A non-contracted supplier is permitted to provide a beneficiary with an item or service listed in the CBP when the supplier properly issues an ABN prior to delivery of the item or service per 42 CFR 414.408(e)(3)(ii) (**http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl**). In order for the ABN to be considered valid when issued under these circumstances, the reason that Medicare may not pay must be clearly and fully explained on the ABN that is signed by the beneficiary.

Sample wording for the "Reason Medicare May Not Pay" blank of the ABN:

Since we are not a contracted supplier, Medicare will not pay for this item. If you get this item from a contracted supplier such as ABC Medical Supplies, Medicare will pay for it.

To be a valid ABN, the beneficiary must understand the meaning of the notice. Suppliers must explain to the beneficiary that Medicare will pay for the item if it is obtained from a different supplier in the area. While some suppliers may be reluctant to direct beneficiaries to a specific contracted supplier, the non-contracted supplier should at least direct the beneficiary to 1-800-MEDICARE to find a local contracted supplier at the beneficiary's request.

Emergencies or Urgent Situations/ Ambulance Transport

In general, a notifier may not issue an ABN to a beneficiary who has a medical emergency or is under similar duress. Forcing delivery of an ABN during an emergency may be considered coercive. ABN usage in the Emergency Room (ER) may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.
Issuance of the ABN is mandatory if all of the following 3 criteria are met:

1. The service being provided is a Medicare covered ambulance benefit under Section1861(s)(7) of the *Social Security Act* (**http://www.ssa.gov/OP_Home/ssact/title18/1861.htm**) and regulations under this section as stipulated in 42 CFR 410.40 - .41 (**http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl**);
2. The provider believes that the service may be denied, in part or in full, as "not reasonable and necessary" under Section 1862(a)(1)(A) for the beneficiary on that particular occasion; and
3. The ambulance service is being provided in a non-emergency situation. (The patient is not under duress.)

Simplified, there are three questions to ask when determining if an ABN is required for an ambulance transport. If the answer to all of the following 3 questions is "yes", an ABN must be issued:

1. Is this service a covered ambulance benefit? AND
2. Will payment for part or all of this service be denied because it is not reasonable and necessary? AND

3. Is the patient stable and the transport non-emergent?

Example: A beneficiary requires ambulance transportation from her Skilled Nursing Facility (SNF) to dialysis but insists on being transported to a new dialysis center 10 miles beyond the nearest dialysis facility. Medicare covers this type of transport; however, since this particular transport is not to the nearest facility, it is not considered a covered Medicare benefit. Therefore, NO ABN is required. As a courtesy to the beneficiary, an ABN could be issued as a voluntary notice alerting her to the financial responsibility.

Example: A beneficiary requires non-emergent ground transport from a local hospital to the nearest tertiary hospital facility; however, his family wants him taken by air ambulance. The ambulance service is a covered benefit, but the level of service (air transport) is not reasonable and necessary for this patient's condition. Therefore, an ABN MUST be issued prior to providing the service in order for the provider to shift liability to the beneficiary.

ABN issuance is mandatory only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. If an ambulance transport is statutorily excluded from coverage because it fails to meet Medicare's definition of the ambulance benefit, a voluntary ABN may be issued to notify the beneficiary of his/her financial liability as a courtesy.

Special Issues Associated with the ABN for Hospice Providers

General Use - Hospice

Mandatory use of the ABN is very limited for hospices. Hospice providers are responsible for providing the ABN when required as listed below for items and services billable to hospice. Hospices are not responsible for issuing an ABN when a hospice patient seeks care outside of the hospice's jurisdiction. The three situations that would require issuance of the ABN by a hospice are:

- Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in Section1879(g)(2) of the Act;
- Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either Section1862(a)(1)(A) or 1862(a)(1)(C); or
- The level of hospice care is determined to be not reasonable or medically necessary as defined in Section1862(a)(1)(A) or 1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

End of All Medicare Covered Hospice Care

When it is determined that a beneficiary who has been receiving hospice care is no longer terminally ill and the patient is discharged from hospice, the hospice must issue the Notice of Medicare Noncoverage (NOMNC), CMS 10123 (see the "FFS ED Notices" link on the CMS website at **http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html** for details). If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the noncovered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.

Hospice Care Delivered by Non-Hospice Providers

It is the hospice's responsibility to issue an ABN when a beneficiary who has elected the hospice benefit chooses to receive inpatient hospice care in a hospital that is not under contract with the hospice. The hospice may delegate delivery of the ABN to the hospital in these cases.

The ABN must not be issued when the face to face requirement for hospice recertification is not met within the required timeframe. Failure to meet the face to face requirement for recertification should not be misrepresented as a determination that the beneficiary is no longer terminally ill. However, in this situation, the hospice would be required to issue a Notice of Medicare Noncoverage (NOMNC), CMS 10123, before the end of all covered care. (See the "FFS ED Notices" link on the CMS website at **http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html** for details.)

Since room and board are not part of the hospice benefit, an ABN would not be required when the patient elects hospice and continues to pay out of pocket for long term care room and board.

Special Issues Associated with the ABN for CORFs

Since Comprehensive Outpatient Rehabilitation Facility (CORF) services are billed under Part B, CORF providers must issue the ABN according to the instructions given in this section. The ABN is issued by CORFs before providing a service that is usually covered by Medicare but may not be paid for in a specific case because it is not medically reasonable and necessary.

When all Medicare covered CORF services end, CORF's are required to issue a notice regarding the beneficiary's right to an expedited determination called a Notice of Medicare Noncoverage (NOMNC), CMS 10123. Please see the "FFS ED Notices" link on the CMS website at **http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html** for these notification requirements. Upon termination of all CORF care, the ABN would be issued only if the beneficiary wants to continue receiving some or all services that will not be covered by Medicare because they are no longer considered medically reasonable and necessary. An ABN would not be issued if no further CORF services are provided.

Additional Information

The official instruction, CR 7821, issued to your Medicare Carrier, FI, RHHI, DME MAC, or A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2480CP.pdf** on the CMS website.

If you have any questions, please contact your carrier, FI, RHHI, DME MAC, or A/B MAC at their toll-free number, which may be found at **http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website. The ABN and instructions can be downloaded from website. The ABN and instructions can be downloaded from website. The ABN and instructions can be downloaded from **http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html** on the CMS website.

ABN - Quick Glance Guide

(This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 50.)

Notice Name: Advance Beneficiary Notice of Noncoverage (ABN)
Notice Number: Form CMS-R-131
Issued by: Providers and suppliers of Medicare Part B items and services;
Hospice and Religious Non-medical HealthCare Institute (RNHCI) providing Medicare Part A items and services
Recipient: Original Medicare (fee for service) beneficiary
Additional Information:

The ABN, Form CMS-R-131 replaces the following notices:

- ABN-G
- ABN-L
- Notice of Exclusion of Medicare Benefits (NEMB)

Type of notice:	Must be issued:	Timing of notice:	Optional/Voluntary
Financial liability notice	• Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice and RNHCI providers only) but may not be paid for in this particular case because it is not considered medically reasonable and necessary • Prior to providing custodial care • For hospice providers, prior to caring for a patient who is not terminally ill • For DME suppliers, additional situations requiring issuance are outlined in Chapter 50.3.1 of the "*Medicare Claims Processing Manual*."	Prior to delivery of the item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.	Yes. Prior to providing an item or service that is never covered by Medicare (not a Medicare benefit).

Appeals for Denied Claims Submitted by an Ordering and Referring Opt-out Physician/Non-physician Practitioners Who Are Excluded by the Office of Inspector General (OIG) (SE1223) (GEN)

MLN Matters® Number: SE1223
Related CR Release Date: N/A
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Provider Types Affected

This MLN Matters® Special Edition Article is intended for opt-out physicians/non-physician practitioners who elect to order and refer and are excluded by the Office of Inspector General (OIG) and who are listed as an eligible professional on a provider submitted claim to Medicare contractors (Carriers, Fiscal Intermediaries (who maintain an HHA workload, RHHIs, and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries which meet exceptions described at 42 CFR 1001.1901(c).

Provider Action Needed

STOP - Impact to You

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to inform opt-out physicians/non-physician practitioners who elect to order and refer and have been excluded by the Office of Inspector General (OIG) that Medicare will soon begin denying Part B, DME, and Part A HHA claims that fail the Ordering/Referring Provider edits. Opt-out physicians/non-physician practitioners who elect to order and refer and have been excluded by the OIG should file an appeal for any claim denials to their carriers and A/B MACs that they believe meets one of the exceptions described at 42 CFR 1001.1901(c).

CAUTION - What You Need to Know

The claims appeal should follow guidelines contained in the "*Medicare Claims Processing Manual*", Chapter 29, Section 290. The appeal should include documentation that proves one of the exceptions described at 42 CFR 1001.1901(c) has been met.

GO - What You Need to Do

See the Background and Additional Information sections of this article for more details.

Background

Medicare requirements for opting out can be found in the "*Medicare Benefit Policy Manual*", Chapter 15, Section 40, which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf** on the CMS website. Opt-out affidavit requirements can be found in the "*Medicare Benefit Policy Manual*", Chapter 15, Section 40.9, which is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf** on the CMS website.

The OIG exclusion does not prohibit a physician/non-physician practitioner from opting out of the Medicare Program. This includes exclusions under the following sections of the Social Security Act:

- Section 1128, Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs, which is available at **http://www.ssa.gov/OP_Home/ssact/title11/1128.htm** on the Internet;
- Section 1156, Obligations of Health Care Practitioners and Providers of Health Care Services, Sanctions, and Penalties, Hearings and Review, which is available at **http://www.ssa.gov/OP_Home/ssact/title11/1156.htm** on the Internet; or
- Section 1892, Offset of Payments to Individuals to Collect Past Due Obligations Arising from Breach of Scholarship and Loan Contract, which is available at **http://www.ssa.gov/OP_Home/ssact/title18/1892.htm** on the Internet.

However, if the opt out physician/non-physician practitioner elects to order and refer services, then 42 CFR 405.425(j) would be applicable. It states that:

"*The physician or practitioner who is excluded under sections 1128, 1156, or 1892 of the Social Security Act may not order, prescribe, or certify the need for Medicare-covered items and services* ***except as provided in §1001.1901 of this title, and must otherwise comply with the terms of the exclusion in accordance with §1001.1901 effective with the date of the exclusion.***"

This article informs opt-out physicians/non-physician practitioners who elect to order and refer and have been excluded by the OIG that they should file an appeal for any claim denials to their carriers and/or A/B MACs. That is, if they believe it meets one of the exceptions described at 42 CFR 1001.1901(c).

- 42 CFR 1001.1901(c) is available at **http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr1001_main_02.tpl** on the Internet.
- The claims appeal should follow the guidelines found in the "*Medicare Claims Processing Manual*", Chapter 29, Section 290. It should also include documentation that proves one of the exceptions described at 42 CFR 1001.1901(c) has been met. The "*Medicare Claims Processing Manual*", Chapter 29, Section 290, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf** on the CMS website.

Additional Information

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

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) and PC Print Update (MM8029) (GEN)

MLN Matters® Number: MM8029
Related CR Release Date: August 17, 2012
Related CR Transmittal #: R2521CP
Related Change Request (CR) #: CR 8029
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8029 which instructs Medicare contractors and Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that have been added since the last recurring code update. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes.

Background

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA; see **http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf** on the Internet), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in remittance advice (RA) and coordination of benefits (COB) transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice (RA), there are two code sets - CARC and RARC - that must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well. Additionally, CARC and RARC must be used for transaction 837 COB.

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. 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 stop using codes that have been deactivated **on or before** the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages **before** the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule.

Note that a deactivated code used in derivative messages must be accepted, even after the code is deactivated, if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR 8029, 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.

CR 8029 lists only the changes that have been approved since the last code update provided by CR 7775 (Transmittal 2442 issued on April 6, 2012; see **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf** on the CMS website).

CR 8029 does not provide a complete list of CARCs and RARCs, and the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website which is updated three times a year (around March 1, July 1, and November 1).

The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

The WPC website (see **http://www.wpc-edi.com/Reference**) has four listings available of Codes by Status for both CARC and RARC.

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

NOTE 1: In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

NOTE 2: CR8029 lists only the changes approved since the last recurring Code Update CR **once**. If any change becomes effective at a future date, Medicare contractors must make sure that they update on the quarterly release date that matches the effective date as posted on the WPC website. If the effective date per the WPC website does not match any quarterly release date, Medicare contractors may update earlier than the effective date per WPC website for any deactivation, and later than the effective date per WPC website for any modification or new code.

CARCs

A national code maintenance committee maintains the health care CARCs, and a new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare.

This code set is updated three times a year, and the updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in the months of January/February, June, and September/October.

The full list of CARCs can be found and downloaded from **http://wpc-edi.com/Reference** and to find out more about CARCs, see the "*Medicare Claims Processing Manual*" (Chapter 22, Sections 60.1 and 130.2 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf** on the CMS website.

New CARCs were approved by the Code Committee, and the following changes were made in the CARC database since the last code update provided by CR 7775. These changes must be implemented, if appropriate for Medicare, by October 1, 2012.

New CARCs

Code	Code Narrative	Effective Date
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/3/2012
241	Low Income Subsidy (LIS) Co-payment Amount.	6/3/2012
242	Services not provided by network/primary care providers.	6/3/2012
243	Services not authorized by network/primary care providers.	6/3/2012

Modified CARCs

Code	Code Narrative	Effective date
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. Use Group Code OA..	6/3/2012

Deactivated CARCs

Code	Code Narrative	Effective Date
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/2013

Remittance Advice Remark Codes (RARCs)

Remittance Advice Remark Codes (RARCs) are maintained by CMS and may be used by any health plan when they apply. Medicare contractors must report appropriate remark code(s) that apply in both electronic and paper remittance advice, and COB claims. RARCs are used in a remittance advice to further explain an adjustment in conjunction with an appropriate CARC or relay general information about the adjudication process.

The remark code list is updated three times a year, and the list as posted at the WPC website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1. Medicare contractors must use the currently valid remark codes as included in the Recurring Update Notification and/or any other CMS instruction. Medicare contractors also must get the full list of RARCs by downloading the list from the WPC website after each update. Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or introduction of newly created codes that may impact Medicare.

The list of Remittance Advice Remark Codes (RARCs) can be found at **http://www.wpc-edi.com/codes** on the Internet.

For more information about Remark Codes

You can find out more about CARCs in the "*Medicare Claims Processing Manual*" (Publication 100-04, Chapter 22, Section 60.2, and 130.3 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf** on the CMS website.

These following changes were made in the RARC database since the last code update provided by CR 7775. The full RARC list must be downloaded from the WPC website at **http://wpc-edi.com/Reference** on the Internet.

New RARCs

Code	Code Narrative	Effective Date
N554	Missing/Incomplete/Invalid Family Planning Indicator	7/1/2012
N555	Missing medication list.	7/1/2012
N556	Incomplete/invalid medication list.	7/1/2012
N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.	7/1/2012
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.	7/1/2012
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.	7/1/2012

Modified RARCs

Code	Modified Code Narrative	Effective Date
N69	PPS (Prospective Payment System) code changed by claims processing system.	7/1/2012
N103	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.	7/1/2012

Deactivated RARCs

None

Medicare contractors must report only currently valid codes in both the RA and COB Claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the Business Requirements segment of CR8029 for explanation of conditions). SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional Information

The official instruction, CR8029, issued to your contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2521CP.pdf** on the CMS website.

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

Claim Status Category and Claim Status Codes Update (MM7905) (GEN)

MLN Matters® Number: MM7905
Related CR Release Date: August 2, 2012
Related CR Transmittal #: R2508CP

Related Change Request (CR) #: CR 7905
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 7905 which explains that the *Health Insurance Portability and Accountability Act* (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee to report the status of submitted claim(s). Proprietary codes may not be used in the X12 276/277 to report claim status. The code sets are available at **http://www.wpc-edi.com/content/view/180/223/** on the Internet. The code lists include the date when a code was added, changed, or deleted. All code changes approved during the June 2012 committee meeting should have been posted on that site on or about July 1, 2012.

Background

HIPAA requires all health care benefit payers to use Claim Status Category Codes and Claim Status Codes to report the status of submitted claim(s). Only codes approved by the National Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format are to be used. Proprietary codes may not be used in the X12 276/277 to report claim status.

The National Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The code sets are available at **http://www.wpc-edi.com/content/view/180/223/** (previously **http://www.wpc-edi.com/codes**) on the Internet. The code lists include specific details, including the date when a code was added, changed, or deleted. Your Medicare contractors must complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes by October 1, 2012.

Additional Information

The official instruction, CR7905, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2508CP.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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

MLN Matters® Number: MM7355 Revised
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R87MSP

Related Change Request (CR) #: 7355
Effective Date: January 1, 2013
Implementation Date: January 7, 2013

Note: *This article was revised on August 3, 2012, to reflect the revised CR7355 issued on August 3. In the article, the CR release date, transmittal number, effective and implementation dates (see above), and the Web address for accessing CR7355 were revised. In addition, a reference to remittance advice remark code M32 was deleted. All other information is the same.*

Provider Types Affected

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

Provider Action Needed

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

Background

CR7355, from which this article is taken: 1) Clarifies the procedures to follow when submitting liability insurance (including self-insurance), no-fault insurance and WC claims when the liability insurer (including self-insurance), no-fault insurer and WC carrier

does not make prompt payment or cannot reasonably be expected to make prompt payment; 2) Defines the promptly payment rules; and 3) Instructs you how to submit liability insurance (including self-insurance), no-fault insurance and WC claims to your Medicare contractors when requesting Medicare conditional payments on these types of MSP claims.

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

Key Points

Conditional Medicare Payment Procedures

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

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

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

"Promptly" Definition

No-fault Insurance and WC "Promptly" Definition

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

Liability Insurance "Promptly" Definition

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

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

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

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

How to Request a Conditional Payment

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

Part A Conditional Payment Requests

Providers of **Part A** services can request conditional non-GHP payments from Part A contractors on the hardcopy Form CMS-1450, if you have permission from Medicare to bill hardcopy claims, or the 837 Institutional Electronic Claim, using the appropriate insurance

value code (i.e., value code 14, 15 or 47) and zero as the value amount. Again, you must bill the non-GHP insurer, and the GHP insurer, if the beneficiary belongs to an employer group health plan, first before billing Medicare.

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

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

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

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

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

Part B Conditional Payment Requests (Table 2)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Situations Where Conditional Payment is Denied

Liability, No-Fault, or WC Claims Denied

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

Denial Codes

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

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

Additional Information

You can find official instruction, CR7355, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC by visiting **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R87MSP.pdf** on the CMS website.

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

Chapter 1 (Background and Overview):

- Section 10.7 (Conditional Primary Medicare Benefits),
- Section 10.7.1 (When Conditional Primary Medicare Benefits May Be Paid When a GHP is a Primary Payer to Medicare), and
- Section 10.7.2 (When Conditional Primary Medicare Benefits May Not Be Paid When a GHP is a Primary Payer to Medicare).

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

- Section 30.2.1.1 (No-Fault Insurance Does Not Pay), and

- Section 30.2.2 (Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation).

Chapter 5 (Contractor Prepayment Processing Requirements):

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

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

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

Note: *This MLN Matters® Article was revised on June 20, 2012, to delete the first bullet point on page 3 and make several grammatical changes. All other information is the same.*

Provider Types Affected

This Special Edition MLN Matters® Article is intended for physicians, non-physician practitioners (including interns, residents, fellows, and also those who are employed by the Department of Veterans Affairs (DVA) or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries, Part B providers and suppliers who submit claims to carriers, Part B Medicare Administrative Contractors (MACs), Part A Regional Home Health Intermediaries, Fiscal
Intermediaries who still have a Home Health Agency (HHA) workload and DME MACs for items or services that they furnished as the result of an order or a referral should be aware of this information.

Provider Action Needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staffs are aware of these updates.

What Providers Need to Know

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

Phase 2: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer.

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

Waiting too late to begin this process could mean that your enrollment application will not be able to be processed prior to the implementation date of Phase 2 of the ordering/referring provider edits.

Background

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

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures; and
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS.
- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:
    - Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
    - Physician Assistant,
    - Certified Clinical Nurse Specialist,
    - Nurse Practitioner,
    - Clinical Psychologist,
    - Interns, Residents, and Fellows,
    - Certified Nurse Midwife, and
    - Clinical Social Worker.

Questions and Answers Relating to the Edits

1. What will the edits do?

The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and it contains a valid National Provider Identifier (NPI) (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits are being implemented in two phases:

- **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message (*The informational messages vary depending on the claims processing system.*) in the Medicare Remittance Advice (*DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.*) indicating that the claim failed the ordering/referring provider edits.

The informational message will indicate that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that does not pass the edits will indicate that the claim/service lacks information that is needed for adjudication. The informational messages are identified below:

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

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

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

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

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

N272	Missing/incomplete/invalid other payer attending provider identifier

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

Note: *if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.*

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

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

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

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

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

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

In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs. (*NPIs were added only when the matching criteria verified the NPI.*)

On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the

Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a bi-weekly basis. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report, and to download it, go to

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

Effect of Edits on Providers

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

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

1. **You have a current Medicare enrollment record.**
   - If you are not sure you are enrolled in Medicare, you may: (1) check the Ordering Referring Report mentioned above, and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI; (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or (3) use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare). If you choose (3), please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.
   - **If you do not have an enrollment record in Medicare:**
     - You need to submit an enrollment application to Medicare in one of two ways:
       a. **Use Internet-based PECOS** to submit your enrollment application over the Internet to your designated Medicare enrollment contractor. You will have to either e-sign the certification statement or mail a printed, signed, and dated Certification Statement and any required supporting paper documentation, to your designated Medicare enrollment contractor. The designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement. If you will be using Internet-based PECOS, please visit the Medicare provider/supplier enrollment web page to learn more about the web-based system before you attempt to use it. Go to **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html**, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.
       b. **Submit an electronic application through the use of internet-based PECOS or obtain a paper enrollment application**, fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor. If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (**http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html**).

NOTE about physicians/non-physician practitioners who have opted-out of Medicare but who order and refer: Physicians and non-physician practitioners who have opted out of Medicare may order items or services for Medicare beneficiaries. Their opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit).

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

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

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

You need to use due diligence to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records (i.e., they have Medicare enrollment records that contain their NPIs) and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering

Referring Report described earlier in this article. Ensure you are correctly spelling the Ordering/Referring Provider's name. If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits. Keep in mind that this Ordering Referring Report will be replaced bi-weekly to ensure it is current. It is possible, therefore, that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report. You may appeal a claim that did not initially pass the Ordering/Referring provider edits.

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

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

Additional Guidance

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

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

3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare.** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

4. **Orders or referrals by dentists.** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review MLN Matters® Article SE1201 (**http://www.cms.gov/Outreach-and- Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf**) for important reminders on the requirements for Ordering and Referring Physicians.

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

Handling Form CMS-1500 Claims Where an ICD-9-CM "E" Code is Reported as the First Diagnosis on the Claim (MM7700) (GEN)

MLN Matters® Number: MM7700
Related CR Release Date: August 8, 2012
Related CR Transmittal #: R2515CP

Related Change Request (CR) #: 7700
Effective Date: Claims received with an "E" code on or after January 1, 2013

Implementation Date: April 1, 2013

Provider Types Affected

Physicians, providers, and suppliers who submit Medicare claims to Medicare Carriers, Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment MACs (DME MACs) using the paper claim Form CMS-1500.

Provider Action Needed

This Change Request (CR) 7700 provides new instructions to return as unprocessable claims submitted on the Form CMS-1500 where an ICD-9-CM "E" Code (external causes of injury and poisoning) is reported as the first/principal diagnosis on the claim.

Background

CR7700 will bring the policy for handling form CMS-1500 claims into alignment with the policy for handling claims initially submitted in electronic format. The ICD-9-CM code set prohibits an "E" code from being reported as principal diagnosis (first-listed) on a claim. This guidance also applies to V00-Y99 (external causes of morbidity) equivalent ICD-10 CM diagnosis codes. Therefore, if an "E" code or V00-Y99 range ICD-10 CM diagnosis code is the first listed diagnosis code on the CMS-1500, the claim would not conform to the ICD-9-CM code set and electronic transmission of the electronic claim to a Coordination of Benefits Agreement (COBA) trading partner would not be *Health Insurance Portability and Accountability Act* (HIPAA) compliant.

Claims initially submitted as electronic claims will, effective April 1, 2012, be rejected in accordance with an edit established by CMS CR7596 when the principal (first) diagnosis code presented in the diagnosis code field is an "E" code or, effective with the implementation of ICD-10, when the principal (first) diagnosis is a code within the code range V00-Y99 of the ICD-10- CM code set. This procedure will prevent those non-HIPAA compliant claims from being adjudicated and then transmitted to the Coordination of Benefits Contractor (COBC) for COBA crossover purposes. CR7700 applies this reasoning to claims submitted on CMS-1500 on or after January 1, 2013.

Key Points

Be aware of the following:

- For claims received via form CMS-1500 on or after April January 1, 2013, Medicare contractors will return as unprocessable claims for items or services where a diagnosis code is required and the diagnosis code reported in the Number 1 field of Item 21 of the Form CMS-1500 is an ICD-9-CM "E" code (external causes of injury and poisoning) or, upon ICD-10 implementation, an ICD-10 CM code within the code range of V00-Y99
- Reprocessed/adjustment claims failing these edits will be denied.
- Claims returned or denied as a result of these edits will show remittance advice remarks code message MA63 (Missing/incomplete/invalid principal diagnosis) and claim adjustment reason code 16 (Claim/service lacks information which is needed for adjudication).

Additional Information

The official instruction, CR7700, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2515CP.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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Healthcare Provider Taxonomy Codes (HPTC) Update, October 2012 (MM8021) (GEN)

MLN Matters® Number: MM8021
Related CR Release Date: August 31, 2012
Related CR Transmittal #: R2534CP

Related Change Request (CR) #: CR 8021
Effective Date: October 1, 2012
Implementation Date: January 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare contractors (carriers and Part B Medicare Administrative Contractors (B MACs)) for services to Medicare beneficiaries.

What You Need to Know

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) Web site at **http://www.wpc-edi.com/codes** on the Internet.

CR 8021 implements the NUCC HPTC code set that is effective on October 1, 2012. The changes for October consist of the addition of two new HPTCs, both under the Individual Section, for Dental Provider types:

- 125J00000X Dental Therapist Classification; and
- 125K00000X Advanced Practice Dental Therapist Classification.

There are no other changes to the October 2012 code set.

Medicare does not use HPTCs to adjudicate its claims. It would not expect to see these codes on a Medicare claim. However, currently, it validates any HPTC that a provider happens to supply against the NUCC HPTC code set.

Additional Information

The official instruction, CR 8021 issued to your carrier or B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2534CP.pdf** on the CMS website.

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

Important Reminder About Medicare Secondary Payer Laws (SE1227) (GEN)

MLN Matters® Number: SE1227
Related CR Release Date: N/A
Related CR Transmittal #: N/A

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

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and other suppliers that are taking payment from beneficiaries upon an office or hospital visit when the Medicare beneficiary has a group health plan that is primary to Medicare. The Centers for Medicare & Medicaid Services (CMS) is issuing this article as an important reminder and the article reflects no change in current Medicare policy.

Provider Action Needed

STOP - Impact to You

This article is based on information received from Medicare contractors (carriers and Medicare Administrative Contractors (MACs)) indicating that physicians, providers and other suppliers are requesting a Medicare deductible, coinsurance payment, or other payments from a beneficiary prior to or at the time of services being rendered when another payer is primary to Medicare.

CAUTION - What You Need to Know

It is against the Medicare Secondary Payer laws to accept payment from a beneficiary upon admission or when services are being rendered when another insurer is primary to Medicare. If you are performing this practice, you must stop immediately.

GO - What You Need to Do Go Light

Participating Medicare providers, physicians, and other suppliers must not accept from the beneficiary any co-payment, coinsurance, or other payments, upon services rendered when the primary payer is an employer Managed Care Organization (MCO) insurance, or any other type of primary insurance such as an employer group health plan. Providers must follow the Medicare Secondary Payer rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary, if anything, after Medicare makes its payment. NOTE: In situations where you have taken payment from the beneficiary when services were rendered, the beneficiary has the right to recoup his/her payment from you when reimbursement is warranted.

Background

Section 1862(b)(2)(A)(i) of the *Social Security Act* precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made under a group health plan with respect to: (i) A beneficiary entitled to Medicare on the basis of ESRD during the first 30 months of that entitlement; (ii) A beneficiary who is age 65 or over, entitled to Medicare on the basis of age, and covered under the plan by virtue of his or her current employment status or the current employment status of a spouse of any age; or (iii) A beneficiary who is under age 65, entitled to Medicare on the basis of disability, and covered under the plan by virtue of his or her current employment status or the current employment status of a family member.

Additional Information

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

Important Reminders about HIPAA 5010 & D.0 Implementation (SE1106) (GEN)

MLN Matters® Number: SE1106 Revised
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Note: ***This article was updated on August 14, 2012, to reflect current Web addresses. It was also revised on June 15, 2012, to include this statement that enforcement of the HIPAA 5010/D.0 standards will begin on July 1, 2012.*** *Also, remember that when claims use nonspecific procedure codes, a corresponding description of the service is now required. All other information remains the same.*

Provider Types Affected

This Special Edition MLN Matters® Article is intended for all 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.

Provider Action Needed

STOP - Impact to You

The implementation of HIPAA 5010 and D.0 presents substantial changes in the content of the data that you submit with your claims as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers. It is important for new providers enrolling in Medicare to know that Electronic Data Interchange (EDI) transactions are the normal mode of business for Medicare claims, claim status, and remittance advice.

CAUTION - What You Need to Know

Medicare requires the use of electronic claims (except for certain rare exceptions) in order for providers to receive Medicare payment. Effective January 1, 2012, you must be ready to submit your claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. This also is a prerequisite for implementing the new ICD-10 codes. This Special Edition MLN Matters® Article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist you and keep you apprised of progress on Medicare's implementation of the ASC X12 Version 5010 and NCPDP Version D.0 standards. Remember that the HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with Fee-for-Service (FFS) Medicare. Therefore, you must be prepared to implement these transactions with regard to your non-FFS Medicare business as well. Medicare began Level II transitioning to the new formats on January 1, 2011, and will be ending the exchange of current formats on January 1, 2012. While the new claim format accommodates the ICD-10 codes, ICD-10 codes will not be accepted as part of the 5010 project. Separate MLN Matters® articles will address the ICD-10 implementation.

GO - What You Need to Do

In preparing for the implementation of these new ASC X12 and NCPDP standards, providers should also consider the requirements for implementing the ICD-10 code set as well. You are encouraged to prepare for the implementation of these standards or speak with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

Background

The *Health Insurance Portability and Accountability Act* (HIPAA) requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

It is important that new providers enrolling in Medicare know that EDI transactions are the normal mode of business for Medicare claims, claim status, and remittance advice. More information about Medicare's EDI requirements can be found in the "*Medicare Claims Processing Manual*," Chapter 24 - "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims," at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c24.pdf** on the CMS website. Electronic billing and EDI transaction information can be found at **http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html** on the CMS website. This section contains information on:

- EDI transaction and corresponding paper claims requirements;
- Links to those chapters of the "*Medicare Claims Processing Manual*" that contain further information on these types of transactions;
- The *Administrative Simplification Compliance Act* (ASCA) requirement that claims be sent to Medicare electronically as a condition for payment;
- How you can obtain access to Medicare systems to submit or receive claim or beneficiary eligibility data electronically; and
- EDI support furnished by Medicare contractors.

Current versions of the transaction standards (ASC X12 Version 4010/4010A1 for health care transactions, and the NCPDP Version 5.1 for pharmacy transactions) are widely recognized as lacking certain functionality that the health care industry needs. Therefore, on January 16, 2009, HHS announced a final rule that replaced the current Version 4010/4010A and NCPDP Version 5.1 with Version 5010 and Version D.0, respectively. The final rule (CMS-0009-F) titled, "Health Insurance Reform; Modifications to the *Health Insurance Portability and Accountability Act* (HIPAA) Electronic Transaction Standards," can be found at **http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-740.pdf** on the Internet.

Subsequently, CMS is performing activities to convert from processing the ASC X12 Version 4010A1 to HIPAA ASC X12 Version 5010, and the NCPDP Version 5.1 to NCPDP Version D.0.

HHS is permitting the dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date of the regulation until January 1, 2012, the fully compliant (Level I and Level II Compliance) date to facilitate testing subject to trading partner agreement.

- **Level I compliance** means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

- **Level II compliance** means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

The CMS Medicare Fee-for-Service implementation schedule is:
- **Level I** April 1, 2010, through December 31, 2010;
- **Level II** January 1, 2011, through December 31, 2011; and
- **Fully compliant** on January 1, 2012.

CMS has prepared a comparison of the current ASC X12 HIPAA EDI standards (Version 4010/4010A1) with Version 5010, and NCPDP EDI standards Version 5.1 with Version D.0. For more information see **http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html** on the CMS website.

CMS has made the side-by-side comparison documents available to interested parties without guarantee and without cost. The documents are available for download in both Microsoft Excel and PDF formats.

The comparisons were performed for Medicare Fee-for-Service business use and while they may serve other uses, CMS does not offer to maintain for purposes other than Medicare Fee-for-Service. Maintenance will be performed without notification, as needed to support Medicare Fee-for-Service.

Readiness Assessment 1- Have you done the following to be ready for 5010/D.0?
Are you ready for 5010/D.0? Testing with external trading partners began in January of 2011. Testing with version 5010A1 Errata will begin in April 2011. Please don't wait until April to begin testing because compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.

Visit **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/readiness_1.pdf** to see a summary of information that is important for your readiness assessment.

Do not wait to begin testing with your MAC because the MACs may not be able to accommodate large volumes of trading partners seeking production status all at once. Be sure to start testing Version 5010 and D.0 as early as possible in 2011. Be prepared.

To download readiness checklists and a resource card with helpful web links go to **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html** on the CMS website.

Readiness Assessment 2 - What do you need to have in place to test with your MAC?
Providers/trading partners should make it a priority to test early during calendar year 2011 with their MACs for the implementation of Versions 5010 and D.0 transactions so as not to impact future Medicare claim processing.
- Trading partner testing for the 5010 base version began with MACs on January 1, 2011.
- Testing with the 5010 errata version (5010A1) will be available for testing in April 2011.
- Successful testing with your MAC is required prior to being placed into production.

Prior to testing, trading partners should ensure their billing service, clearinghouse, or software vendor:
- Has passed testing requirements for each transaction (testing with each Medicare contractor or a certification system that the Medicare contractor has accepted); and
- Is using the same program/software to generate the transaction for all of their clients.

Details about Medicare testing requirements and protocols and the 5010 National Call presentation on Provider Outreach and Education - Transition Year Activities can be found at **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf** on the CMS website.

Trading partners are encouraged to review the following:

- Version 5010 and D.0. transaction resources can be found at **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html** on the CMS website;
    - Educational Resources (i.e., Medicare Learning Network® (MLN) articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, frequently asked questions, and transcripts from previous national provider calls) can be found at **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html** on the CMS website; and
- The dedicated HIPAA 5010/D.0 Project web page, which includes technical documents and communications at national conferences, can be found at **http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html** on the CMS website.

Errata Requirements and Testing Schedule

HIPAA Version 5010 has new Errata, which can be found at **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Errata_Req_and_Testing.pdf** on the CMS website. According to the published regulation (Federal Register, Vol. 74, No. 11, 3296-3328, January 16, 2009; RIN 0938-AM50 of 45 CFR Part 162), testing with external trading partners must begin in January of 2011. **Compliance with the Errata must be achieved by the original regulation compliance date of January 1, 2012.**

Medicare FFS will implement the errata versions of the affected 5010 transactions to meet HIPAA compliance requirements, and Medicare FFS contractors will be ready to test the 5010 Errata versions in April 2011.

Transactions not impacted by the errata can be tested starting January 2011 without regard to the published errata schedule. Trading Partners should contact their local Medicare FFS contractor for specific testing schedules. To find a Medicare FFS contractor in your state, please refer to the "Downloads" section at **http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html** on the CMS website.

CMS 5010 Provider Outreach and Education Materials

CMS has developed extensive information and educational resources pertaining to the topics listed below. This information is available on the CMS website:

- Version 5010- the new version of the X12 standards for HIPAA transactions;
- Version D.0 - the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions;
- Version 3.0 - a new NCPDP standard for Medicaid pharmacy subrogation.

The information posted at **http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html** on the CMS website may be applicable to the healthcare industry at large, or may be specifically Medicare-related information. The "Overview" web page is designed to distinguish the Medicare-related information from the industry related.

Please note there are separate resource pages for D.0 and 3.0 for tools and information specific to these pharmacy-related standards. The highlights and overview of these pages are as follows:

- **Federal Regulation & Notices** (**http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html**) This web page contains general information related to federal regulations and notices and contains the following link to the Final Rule for X12 5010, D.0 and3.0 document. See **http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-740.pdf** on the Internet
- **CMS Communications** (**http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html**) This CMS Communications web page includes Versions 5010 & D.0 implementation information and the following downloads:
    - *5010 Implementation Calendar* [PDF, 325KB]; see **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/5010ImplementationCalendar.pdf** on the CMS website.

- *Readiness Assessment - What do you need to have in place to test with your MAC?* [PDF, 241KB]; see **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Readiness_2.pdf** on the CMS website.

- **Educational Resources (http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html)** The Educational Resources web page includes information designed to increase national awareness and assist in the implementation of Versions 5010, D.0 and 3.0. Products that target a specific population, such as Medicare FFS, are clearly identified. Otherwise, products and information may be appropriate for the healthcare industry at large. This Web page includes the following downloads:
  - **Version 5010 Resource Card [PDF, 243KB]** (see **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/5010EDI_RefCard_ICN904284.pdf**);
  - **Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0 Fact Sheet [PDF, 1208KB]** (see **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010TransitionFctSht.pdf**);
  - **Checklist for Level I Testing Activities [PDF, 324 KB]** (see **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads//w5010PrepChklst.pdf**);
  - **Provider Action Checklist for a Smooth Transition [PDF, 333KB]** (see **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010PvdrActionChklst.pdf**); and
  - **Versions 5010 and D.0 MLN Matters® Articles [PDF, 31KB]** (see **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/Versions_5010_and_D0_MLN_Matters_Articles.pdf** on the CMS website).
- **5010 National Calls -** Throughout the implementation of Version 5010, CMS has been hosting a variety of national education calls that inform the provider community of the steps that they need to take in order to be ready for implementation. These calls also give participants an opportunity to ask questions of CMS subject matter experts. The 5010 web page contains the list of past calls with links to Web pages where you can download the past call presentations, transcripts, and audio files.

Additional Information

A Special Edition MLN Matters® article on the ICD-10 code set can be found at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0832.pdf** on the CMS website.

You may want to review MLN Matters® article SE1131 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1131.pdf**) that references the approaching deadline of January 1, 2012, for 5010 implementation. SE1131 urges providers to contact their MACS for the free Version 5010 software and begin testing to avoid delays in payment for Fee-For-Service claims.

CMS is also using the Open Door Forums and listservs to keep providers informed of its implementation progress and will also use these vehicles to assist providers in preparing for the new standards. Information on the Open Door Forums can be found at **http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html** on the CMS website.

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

Important Update Regarding 5010/D.0 Implementation - Action Needed Now (SE1131) (GEN)

MLN Matters® Number: SE1131 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 June 15, 2012, to include this statement that enforcement of the HIPAA 5010/D.0 standards will begin on July 1, 2012.*** *Also, remember that when claims use nonspecific procedure codes, a corresponding description of the service is now required. All other information remains the same.*

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.

Provider Action Needed

STOP - Impact to You

You and your billing and software vendors must be ready to begin processing the *Health Insurance Portability and Accountability Act* (HIPAA), Versions 5010 & D.0 production transactions by December 31, 2011. Beginning January 1, 2012, all electronic claims, eligibility and claim status inquiries, must use Versions 5010 or D.0. Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in the 5010 version.

CAUTION - What You Need to Know

You must comply with this important deadline to avoid delays in payments for Medicare Fee-For-Service (FFS) claims after December 31, 2011. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

GO - What You Need to Do

Contact your MACs to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, which are available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/index.html** on the CMS website. Part A providers may download the free PC-Print software to view and print compliance HIPAA 5010 835 remittance advices, which is available on your A/B MACs website. Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Background

HIPAA requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards that covered entities (health plans, health care clearinghouses, and certain health care providers) must use when they electronically conduct certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others.

The implementation of HIPAA 5010 and the National Council for Prescription Drug Programs (NCPDP) Version D.0 presents substantial changes in the content of the data that you submit with your claims, as well as the data available to you in response to your electronic inquiries. The implementation requires changes to the software, systems, and perhaps procedures that you use for billing Medicare and other payers.

Version 5010 refers to the revised set of HIPAA transaction standards adopted to replace the current Version 4010/4010A standards. Every standard has been updated, from claims to eligibility to referral authorizations.

All HIPAA covered entities must transition to Version 5010 by January 1, 2012. Any electronic transaction for which a standard has been adopted must be submitted using Version 5010 on or after January 1, 2012. Electronic transactions that do not use Version 5010 are not compliant with HIPAA and will be rejected.

To allow time for testing, CMS began accepting electronic transactions using either Version 4010/4010A or Version 5010 standards on January 1, 2011, and will continue to do so through December 31, 2011. This process allows a provider and its vendors to complete end-to-end testing with Medicare contractors and demonstrate that they are able to operate in production mode with Versions 5010 and D.0.

Note: *HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your transactions with all payers, not just with FFS Medicare. Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business as well.*

Are You at Risk of Missing the Deadline?

If you can answer **NO** to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and not being able to submit claims:

1. Have you contacted your software vendor (if applicable) to ensure that they are on track to meet the deadline or contacted your MAC to get the free Version 5010 software (PC-Ace Pro32)?
2. Alternatively, have you contacted clearinghouses or billing services to have them translate your Version 4010 transactions to Version 5010 (if not converting your older software)?
3. Have you identified changes to data reporting requirements?
4. Have you started to test with your trading partners, which began on January 1, 2011?
5. Have you started testing with your MAC, which is required before being able to submit bills with the Version 5010?
6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

Additional Information

MLN Matters® article MM7466, "Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7466.pdf** on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "Preparing for Electronic Data Interchange (EDI) Standards: The Transition to Versions 5010 and D.0," is available at **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/downloads/w5010TransitionFctSht.pdf** on the CMS website.

MLN Matters® Special Edition article SE1106 titled "Important Reminders about HIPAA 5010 & D.0 Implementation," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1106.pdf** on the CMS website. MLN Matters® Special Edition article SE1138 is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1138.pdf** on the CMS website.

Additional educational resources about HIPAA 5010 & D.0 are available at **http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html** on the CMS website.

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

Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs) (SE1231) (MOB)

MLN Matters® Number: SE1231
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 Medicare Fee-For-Service (FFS) suppliers who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Power Mobility Devices (PMDs) in the demonstration states (California, Texas, Florida, Michigan, Illinois, North Carolina, and New York). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

What You Need to Know

PMDs includes power wheelchairs and Power-Operated Vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of Durable Medical Equipment (DME) for Medicare coverage purposes.

Power Operated Vehicles (POVs or scooters): Under the Mobility Assistive Equipment (MAE) National Coverage Determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, or manually operated wheelchair. In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

Power (Motorized) Wheelchairs: Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare Fee-For-Service Program. CMS is conducting a 3-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines **beginning with orders written on or after September 1, 2012**. The demonstration will be conducted in seven States with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. These States accounted for 43 percent of the $606 million total Medicare PMD expenditures in 2010. This demonstration targets a claim type known to be susceptible to fraud and that have high rates of improper payments.

The demonstration will implement a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration States. The prior authorization request can be completed by the ordering physician/ practitioner or the DME supplier. The physician/ practitioner or supplier who submits the request is referred to as the "submitter." The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration States:

- Group 1 Power Operated Vehicles (K0800-K0802 and K0812);
- All standard power wheelchairs (K0813 through K0829);
- All Group 2 complex rehabilitative power wheelchairs (K0835 through K0843);
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855);

- Pediatric power wheelchairs (K0890-K0891); and
- Miscellaneous power wheelchairs (K0898).

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary's home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the 7 element order, the detailed product description and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/ practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 48 hours. Claims with affirmative prior authorization requests will be paid so long as all other Medicare coverage and documentation requirements are met. **Claims with a non-affirmative prior authorization decision will not be paid by Medicare.**

If a second prior authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/ practitioner and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision; however, the claim will still be subject to prepayment review. Beginning for orders written on or after December 1, 2012, CMS will assess a payment reduction for noncompliance with the prior authorization process. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS competitive bidding program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration. Additional information and updates on the demonstration will be posted at **http://Go.cms.gov/PADemo** on the CMS website.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

Key Points

CMS will initially conduct this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on beneficiary address as reported to the Social Security Administration and recorded in Medicare's Common Working File (CWF). This demonstration will involve all four DME MACs. This demonstration will begin for orders written on or after September 1, 2012.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

Additional Information

The Prior Authorization of Power Mobility Device Section of the CMS webpage is at **http://Go.cms.gov/PADemo**.

MLN Matters® Special Edition Article SE1112, "Power Mobility Device Face-to-Face Examination Checklist," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf** on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements," is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf** on the CMS website.

Please visit **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html** for the latest MLN educational products designed to help Medicare FFS Providers understand - and avoid - common billing errors and other improper activities.

October 2012 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files (MM7885) (DRU)

MLN Matters® Number: MM7885
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R2514CP
Related Change Request (CR) #: CR 7885
Effective Date: October 1, 2012
Implementation Date: October 1, 2012

Provider Types Affected

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

Provider Action Needed

STOP - Impact to You

Medicare will use the October 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 October 1, 2012, with dates of service from October 1, 2012, through December 31, 2012.

CAUTION - What You Need to Know

Change Request (CR) 7885, from which this article is taken, instructs your Medicare contractors to download and implement the October 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 July 2012, April 2012, January 2012, and October 2011 files.

GO - What You Need to Do

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

Background

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "*Medicare Claims Processing Manual*" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf** on the CMS website.)

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

Files	Effective for Dates of Service
October 2012 ASP and ASP NOC	October 1, 2012, through December 31, 2012
July 2012 ASP and ASP NOC	July 1, 2012, through September 30, 2012
April 2012 ASP and ASP NOC	April 1, 2012, through June 30, 2012
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011

Additional Information

You can find the official instruction, Change Request (CR) 7885, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2514CP.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.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

October Quarterly Update to 2012 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement (MM7856) (GEN)

MLN Matters® Number: MM7856 Revised
Related CR Release Date: June 27, 2012
Related CR Transmittal #: R2492CP

Related Change Request (CR) #: CR 7856
Effective Date: January 1, 2012
Implementation Date: October 1, 2012

Note: *This article was revised on June 29, 2012, to reflect the revised CR7856, issued on June 27. The CR was revised to show that it also applied to providers/suppliers submitting claims to DME MACs. Also, the CR release date, transmittal number, and the Web address for accessing the CR have been revised. All other information remains the same.*

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and/or A/B Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment (DME) MACs) for Skilled Nursing Facility (SNF) services provided to Medicare beneficiaries.

Provider Action Needed

The changes noted in Change Request (CR) 7856, which apply to the "*Medicare Claims Processing Manual*," Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 10.1 (Consolidated Billing Requirement for SNFs), allow for correct processing of claims under the Skilled Nursing Facility Consolidated Billing provisions. For the October 2012 update, the only change is the addition of Healthcare Common Procedure Coding System (HCPCS) code J9033 (Injection, bendamustine hcl, 1 mg) to the File 1 Coding List for SNF Consolidated Billing (CB) for dates of service on or after January 1, 2012. Please note that, when brought to their attention, your Medicare contractor will re-open and re-process claims for J9033 with dates of service on or after January 1, 2012, that have been previously denied prior to the implementation of CR7856.

Background

Section 1888 of the *Social Security Act* (see **http://www.ssa.gov/OP_Home/ssact/title18/1888.htm**) codifies the Skilled Nursing Facility Prospective Payment System (SNF PPS) and Consolidated Billing (CB); and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. These updates (which do not add any additional services) are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when, and if, they occur.

To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries that are both included and excluded from SNF CB. You should be aware that Medicare will not pay any providers (other than SNFs) for services included in

SNF CB that appear on claims submitted to Medicare Carriers, A/B MACs, and Durable Medical Equipment MACs (DME MACs). However services excluded from SNF PPS and CB may be paid to providers (other than SNFs) for beneficiaries, even when in a SNF stay.

SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay; but applies to non-therapy services only when the services are furnished to a SNF resident during a covered Part A stay.

Additional Information

The official instruction, CR7856 issued to your carrier, DME MAC, or A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2492CP.pdf** on the CMS website.

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

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

MLN Matters® Number: SE1221
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

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

Provider Action Needed

STOPP - Impact to You

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

CAUTION - What You Need to Know

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

GO - What You Need to Do

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare... You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O).

Background

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

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

- **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message in the remittance advice indicating that the claim failed the ordering/referring provider edits.

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

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

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

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

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

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

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

N272	Missing/incomplete/invalid other payer attending provider identifier

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

Note: *if the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid.*

- **Phase 2: CMS has not announced a date when the edits for Phase 2 will become active.** CMS will give the provider community at least 60 days notice prior to turning on these edits. During Phase 2, Medicare will deny Part B, DME and Part A HHA claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items

or services need to be enrolled in Medicare and must be of a specialty that is eligible to order and refer. If the billed service requires an ordering/referring provider and the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, but is not enrolled in Medicare, the claim will not be paid. In addition, if the ordering/referring provider is on the claim, but is not of a specialty that is eligible to order and refer, the claim will not be paid. Below are the denial edits for Part B providers and suppliers who submit claims to carriers including DME:

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

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

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs) (SE1128) (GEN)

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Implementation Date: N/A

Note: *This article was revised on August 28, 2012, to clarify the section of the Social Security Act that prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing (page 2- bold).This article was previously updated on July 25, 2012, to reflect current Web addresses. All other content remains the same.*

Provider Types Affected

All Medicare physicians, providers and suppliers who submit claims to Medicare for services and supplies provided to Qualified Medicare Beneficiaries (QMBs) are affected. This includes providers of services to enrollees of Medicare Advantage plans.

What You Need to Know

STOP - Impact to You

This Special Edition MLN Matters® Article provides guidance from the Centers for Medicare & Medicaid Services (CMS) to Medicare providers serving QMBs. **All Medicare providers are reminded that they may not bill QMBs for Medicare cost-sharing.**

CAUTION - What You Need to Know

All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs must be aware that they may not bill QMBs for Medicare cost-sharing. This includes deductible, coinsurance, and copayments, known as "balance billing." **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the *Balanced Budget Act of 1997*, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing.** QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

GO - What You Need to Do

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staffs are aware of the current balance billing law and policies regarding QMBs. Visit the State Medicaid Agency websites of the states in which you practice to learn how to submit claims if you are not currently submitting claims to a state.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments. This is known as "balance billing."

Balance Billing of QMBs Is Prohibited by Federal Law

Under current law, Medicare providers cannot balance bill a QMB. **Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the *Balanced Budget Act of 1997*, prohibits Medicare providers from balance billing QMBs for Medicare cost-sharing.** (Please note, this section of the Act is available at **http://www.ssa.gov/OP_Home/ssact/title19/1902.htm** on the Internet.)

Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider for services rendered to a QMB.

QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who balance bill QMB patients may be subject to sanctions based on Medicare provider requirements established in Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

Please note that the statute referenced above supersedes Section 3490.14 of the "*State Medicaid Manual*," which is no longer in effect, and therefore, may be causing confusion about QMB billing.

QMBs and Benefits

QMBs are persons who are entitled to Medicare Part A and are eligible for Medicare Part B; have incomes below 100 percent of the Federal Poverty Level; and have been determined to be eligible for QMB status by their State Medicaid Agency.

- Medicaid pays the Medicare Part A and B premiums, deductibles, co-insurance and co-payments for QMBs.
- At the State's discretion, Medicaid may also pay Part C Medicare Advantage premiums for joining a Medicare Advantage plan that covers Medicare Part A and B benefits and Mandatory Supplemental Benefits.
- Regardless of whether the State Medicaid Agency opts to pay the Part C premium, the QMB is not liable for any co-insurance or deductibles for Part C benefits.

Ways to Improve the Claims Process

Effective communications between you and State Medicaid Agencies can improve the claims process for all parties involved. Therefore, CMS suggests that you take the following four actions to improve communications with State Medicaid Agencies and better understand the billing process for services provided to QMB beneficiaries:

1. Determine if the State in which you operate has electronic crossover processes with the Medicare Coordination of Benefits Contractor (COBC) in place or if direct submission to the State Medicaid Agency is required or available. Nearly all States participate in the Medicare crossover process. It may just be that particular QMBs need to be added to the eligibility exchange between given States and Medicare. If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare remittance advice.
2. Recognize that you must meet any state-imposed requirements and may need to complete the provider registration process to be entered into the State payment system.
3. Understand the specific requirements for provider registration for the State(s) in which you work.
4. Contact the State Medicaid Agency directly to determine the process you need to follow to begin submitting claims and receiving payment.

QMB Eligibility and Benefits

Dual Eligibility	Eligibility Criteria	Benefits
Qualified Medicare Beneficiary (QMB only)	• Income cannot exceed 100% of the Federal Poverty Level (FPL) • Resources cannot exceed $6,600 for a single individual or $9,910 for an individual living with a spouse and no other dependents	• Entitled to Medicare Part A • Eligible for Medicaid payment of Medicare Part B premiums, deductibles, co-insurance and co-pays (except for Part D)
QMB Plus	• Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage • Individuals often qualify for full Medicaid benefits by meeting the Medically Needy standards, or through spending down excess income to the Medically Needy level.	• Entitle to all benefits available to QMB, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient

For more information about dual eligible categories and benefits, please visit **http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf** on the Internet.

Additional Information

For more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)," which is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf** on the CMS website.

For general Medicaid information, please visit the Medicaid web page at **http://www.medicaid.gov/index.html** on the CMS website.

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

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Note: *This article was revised on June 7, 2012, to include the full OIG recommendations, to make several minor clarifications, and to delete a reference to recent legislation requiring face-to-face encounters for certain DMEPOS. All other information is the same.*

Provider Types Affected

This MLN Matters® Special Edition Article is intended for providers who bill Medicare for lower limb prostheses. No new policies are contained in this article.

What You Need to Know

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

The study was designed to meet the following objectives:

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

Background

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

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

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

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

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

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

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

Findings:

In 2009, the study found that:

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

Recommendations

The OIG made six recommendations based upon their findings. The Centers for Medicare & Medicaid Services (CMS) concurred with five of the six recommendations made by the OIG. The recommendations and CMS actions are as follows:

OIG Recommendation 1: Implement additional claims processing edits to prevent inappropriate payments. CMS should instruct the four DME MACs to implement claims processing edits based on all of the local coverage determination requirements.

CMS Response: CMS concurred and stated it would instruct the DME MACs to implement consistent claims processing edits based on local coverage determination requirements.

OIG Recommendation 2: Strengthen monitoring of billing for lower limb prostheses. CMS should instruct the DME MACs, ZPICs, and DME PSCs to monitor billing for lower limb prostheses using the measures discussed in this report. CMS should develop thresholds for these measures and instruct its contractors to conduct additional reviews of suppliers that exceed the thresholds.

CMS Response: CMS concurred and stated it would issue guidance to the DME MACs and instruct them to consider the measures used in the OIG report as supplemental criteria for detecting high-risk suppliers.

OIG Recommendation 3: Implement requirements for a face-to-face encounter to establish the beneficiary's need for prostheses. We recommend that CMS implement requirements that the referring physician document that a face-to-face encounter occurred. This would help ensure that lower limb prostheses provided to beneficiaries are medically necessary.

CMS Response: CMS concurred and stated it is exploring its current authorities to implement such requirements. CMS also stated that it would issue an educational article to further explain policy requirements for lower limb prostheses and to providers and suppliers.

OIG Recommendation 4: Revise the requirements in the local coverage determination. CMS should work with the DME MACs to clarify several aspects of the local coverage determination. First, CMS should clarify the definitions of beneficiaries' functional levels. Second, CMS should revise the local coverage determination or take other steps to require that licensed/certified medical professionals, such as physical therapists, evaluate beneficiaries to determine their potential functional levels. Finally, CMS should consider denying as medically unnecessary certain combinations of prostheses.

CMS Response: CMS concurred and stated it would review the definitions for the functional levels and develop refinements as appropriate. CMS also stated it would consider adapting an algorithm to guide determination of the functional status of the beneficiary.

OIG Recommendation 5: Enhance screening for currently enrolled suppliers of lower limb prostheses. Federal regulations place new DMEPOS suppliers at the high-risk level and currently enrolled DMEPOS suppliers at the moderate-risk level. CMS should

consider placing current suppliers of lower limb prostheses at the high-risk level, thus subjecting them to the more rigorous screening procedures.

CMS Response: CMS did not concur and stated that it has in place sufficient tools that allow for increased scrutiny of existing DMEPOS suppliers. CMS noted that if an existing supplier meets one of several triggering events, that supplier automatically is elevated to the high-risk level.

OIG Recommendation 6: Take appropriate action on suppliers with questionable billing. In a separate memorandum, we will refer the suppliers that we identified to CMS for appropriate action.

CMS Response: CMS concurred and stated it would share the information with the DME MACs and the Recovery Audit Contractors. Recovery Audit Contractors review Medicare claims on a post payment basis to identify inappropriate payments.

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

Key Points

Medicare Requirements for Lower Limb Prostheses

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

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

Note: *If a supplier is replacing an old prosthesis and there is no upgrade in the model, the supplier does not need a physician order. Also, the "ordering" physician need not be a surgeon and may be the beneficiary's primary care physician.*

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

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

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

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

Note: *You should ensure that any items or services submitted on Medicare claims are referred or ordered by Medicare-enrolled providers of a specialty type authorized to order or refer the same. You must also place the ordering or referring provider or supplier's NPI on the claim you submit to Medicare for the service or item you provide. You may want to review MLN Matters® Article SE1201 at* ***http://www.cms.gov/MLNMattersArticles/downloads/SE1201.pdf*** *for important reminders on the requirements for Ordering and Referring Physicians.*

Additional Information

If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at **http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

The entire OIG report titled "Questionable Billing By Suppliers of Lower Limb Prostheses" is available at **http://oig.hhs.gov/oei/reports/oei-02-10-00170.pdf** on the OIG website.

Reminder of Importance of Correct Place-of-Service Coding on Medicare Part B Claims (SE1226) (GEN)

MLN Matters® Number: SE1226
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 and their billing agents who submit claims to Medicare Carriers or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to remind providers that accurate place of service coding on claims is essential to avoid improper payments. Make sure that your billing staffs are aware of this article and the need to correctly code the place-of-service on your Medicare claims.

Background

The Medicare Part B Program pays for physician services provided to beneficiaries. Physicians may perform these services in a **facility setting**, such as a hospital outpatient department or freestanding Ambulatory Surgical Center (ASC), or in a **non-facility setting** such as a physician's office, urgent care center, or independent clinic. To account for the increased overhead expenses physicians incur by performing these services in non-facility locations, Medicare reimburses physicians based on a fee schedule that may pay a higher rate for individual services provided in these locations. When physicians perform these services in facility settings, such as hospital outpatient departments or ASCs, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate.

Physicians are required to identify the place-of-service on the health insurance claim forms that they submit to Medicare contractors. The correct place-of- service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the payment if the service was performed in a facility setting.

The Office of Inspector General (OIG) conducted an audit in 2009 that followed up on a similar audit from a 2007 report. The 2009 audit covered 494,129 non-facility-coded physician services valued at $42,245,142. These services were provided in calendar year 2009 and matched hospital outpatient or ASC claims for the same type of service provided to the same beneficiary on the same day.
The OIG conducted the 2009 audit to determine whether physicians correctly coded non-facility place- of-service on selected part B claims submitted to and paid by Medicare contractors. The audit report, titled "Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009" is available at **http://oig.hhs.gov/oas/reports/region10/11000516.pdf** on the OIG website.

Results of Recent OIG Audit

Physicians correctly coded the claims for 17 of the 100 services that the OIG sampled. However, physicians incorrectly coded the claims for 83 sampled services by using non-facility place-of-service codes for services that were actually performed in hospital outpatient departments or ASCs.

Based on the sample results, OIG estimated that nationally, Medicare contractors overpaid physicians $9.5 million for incorrectly coded services provided during calendar year 2009. These overpayments may be due to internal control weaknesses at the physician billing level. They may also be attributed to insufficient post-payment reviews at the Medicare contractor level to identify potential place-of-service coding errors.

As a result, Strategic Health Solutions, a CMS contractor, performed a specialty medical review study on Place-of-Service coding for physician services. This study concluded that the most common finding was documentation submitted indicated that the service was incorrectly coded as a non-facility place of service. In addition, a number of providers acknowledged that the claim was coded incorrectly upon receipt of the documentation, or had already initiated the adjustment process.

Additional Information

For an overview of place of service coding and a list of the appropriate codes, visit **https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html** on the CMS website.

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

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

MLN Matters® Number: MM7499 Revised
Related CR Release Date: July 19, 2012
Related CR Transmittal #: R1101OTN

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

Note: *This article was revised on July 25, 2012, to reflect a revised CR7499 issued on July 19, 2012. The article was revised to show a revised transmittal number, CR release date, and Web address for accessing CR7499. All other information is the same.*

Provider Types Affected

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

Provider Action Needed

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

Background

The Centers for Medicare & Medicaid Services (CMS) generates *Health Insurance Portability and Accountability Act* (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular

basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR6870 and CR7068. The MLN Matters article corresponding to CR6870 can be reviewed at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6870.pdf** and CR7068 can be reviewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R812OTN.pdf** on the CMS website

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

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

CR7499 instructs the shared systems to replace the HIC number being sent on the ERA with the Patient Control Number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA. (DME ERAs (835's) will show a Financial Control Number in positions 1-14 of PLB 03-2 and the Adjustment Claim Control Number in positions 15-29 of PLB 03-2.)

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

Additional Information

The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1101OTN.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.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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

MLN Matters® Number: MM7729 Revised
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R1110OTN

Related Change Request (CR) #: CR 7729
Effective Date: July 1, 2012
Implementation Date: July 2, 2012

Note: *This article was revised on August 7, 2012, to reflect the revised CR7729 released on August 3, 2012. In the article, the CR release date, transmittal number and the Web address for accessing CR7729 have been revised. All other information remains the same.*

Provider Types Affected

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

Provider Action Needed

STOP - Impact to You

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

CAUTION- What You Need to Know

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

GO - What You Need to Do

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

Background

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

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

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

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

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

Additional Information

The official instruction, CR7729, issued to your DME MACs regarding this change may be viewed at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1110OTN.pdf** on the CMS website. If you have any questions, please contact your DME MACs at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (MM7836) (SPE)

MLN Matters® Number: MM7836
Related CR Release Date: August 3, 2012
Related CR Transmittal #: R2511CP and R144NCD

Related Change Request (CR) #: CR 7836
Effective Date: June 8, 2012
Implementation Date: January 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers that submit claims to Medicare contractors (carriers, Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for Transcutaneous Electrical Nerve Stimulation (TENS) services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7836 which informs providers and suppliers that the Centers for Medicare & Medicaid Services (CMS) is revising the coverage for TENS for Chronic Low Back Pain (CLBP) effective for claims with dates of service on or after June 8, 2012. See the Key Points section of this article for specific coverage rules and review the lists of ICD- 9 and ICD-10 codes attached to the official instruction CR7836.

Background

In 2010, the Therapeutic and Technology Assessment Subcommittee of the American Academy of Neurology (AAN) published a report finding TENS ineffective for CLBP. CMS internally initiated a new national coverage determination (NCD) after the AAN published report and reviewed all the available evidence on the use of TENS for the treatment of CLBP.
Medicare has four NCDs pertaining to various uses of TENS that were developed before the CMS adoption of an evidence based and publicly transparent paradigm for coverage decisions. Those four NCDs are:

- Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2);
- Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1);
- Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13); and
- Transcutaneous Electrical Nerve Stimulators (TENS) (280.13). **Please note, section 280.13 has been removed from the NCD manual and incorporated into NCD 160.27**

The evidentiary basis is unclear for historic coverage. TENS has been historically thought to relieve chronic pain but the current evidence base refutes this assertion when applied to TENS for CLBP. Since TENS falls within the durable medical equipment (DME) benefit, Medicare coverage results in purchase after a brief initial rental period, even if the patient soon develops a subsequent tolerance to the TENS effect.

Key Points

Effective for claims with dates of service on or after June 8, 2012, CMS believes the evidence is inadequate to support coverage of TENS for CLBP as reasonable and necessary. Thus, effective for claims with dates of service on and after June 8, 2012, Medicare will only allow coverage of TENS for CLBP defined for this decision as pain for 3 months or longer and not a manifestation of a clearly defined and generally recognizable primary disease entity, when the patient is enrolled in an approved clinical study under coverage with evidence development (CED).

Note: *CED coverage expires three years from the effective date of this CR, June 8, 2015.*

Examples of clearly defined and recognizable primary disease entities: neurodegenerative (e.g. multiple sclerosis) disease, malignancy, or well-defined rheumatic disorders (except osteoarthritis).

Medicare contractors will accept and process line items that include an appropriate TENS HCPCS code, at least one ICD-9 diagnosis code for CLBP (see list of ICD-9 codes attached to CR7836), and all of the following:

- Date of service on or after June 8, 2012;
- Modifiers KX and Q0;
- ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only);
- Condition code 30 - (for institutional claims only)
- An acceptable ICD-9 code; and
- An acceptable ICD-10 code upon implementation (see list of ICD-10 codes attached to CR7836).

Medicare contractors will deny TENS line items on claims when billed with a TENS code and at least one of the ICD-9 or ICD-10 codes for CLBP (see attachments to transmittal R2511CP of CR7836 at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2511CP.pdf**), if the conditions of requirement listed above are not met. When Medicare denies such claims for not containing the requisite ICD-9 (or later ICD-10) code, your remittance advice will reflect the following messages:

- Group Code CO;
- Claim Adjustment Reason Code B5 (Coverage/program guidelines were not met or were exceeded.); and
- Remittance Advice Remark Code N386 (This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at

http://www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Medicare will pay for allowed TENS for CLBP based on the DME fee schedule.

All of the following conditions must be met for coverage of TENS for CLBP:

CLBP is defined as:

- An episode of low back pain that has persisted for three months or longer; and
- **Is not the manifestation of a clearly defined and generally recognizable primary disease entity.**

For example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom. Certain systemic diseases, e.g. rheumatoid arthritis, multiple sclerosis etc, manifest many debilitating symptoms of which low back pain is not the primary focus. CMS believes that the appropriate management of these types of diseases is guided by a systematic strategy aimed at the underlying causes. While TENS may infrequently be used adjunctively in managing the symptoms of these diseases, it is clearly not the primary therapeutic approach.

The patient is enrolled in an approved clinical study that addresses one or more aspects of the following questions in a randomized, controlled design using validated and reliable instruments. This can include randomized crossover designs when the impact of prior TENS use is appropriately accounted for in the study protocol.

1. Does the use of TENS provide a clinically meaningful reduction in pain in Medicare beneficiaries with CLBP?
2. Does the use of TENS provide a clinically meaningful improvement of function in Medicare beneficiaries with CLBP?
3. Does the use of TENS provide a clinically meaningful reduction in other medical treatments or services used in the medical management of CLBP?

These studies must be designed so that the patients in the control and comparison groups receive the same concurrent treatments and either sham (placebo) TENS or active TENS intervention.

The study must also adhere to standards of scientific integrity and relevance to the Medicare population and those standards are part of Section 160.27. You may read the entire set of parameters in the official instruction attached to transmittal R144NCD of CR7836. That transmittal is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R144NCD.pdf** on the CMS website.

Additional Information

The official instruction, CR 7836, issued to your Medicare Carrier, RHHI or DME MAC regarding this change via two transmittals. The first updates the *NCD Manual* and it is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R144NCD.pdf** on the CMS website. The other transmittal updates the "*Medicare Claims Processing Manual*" and it is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2511CP.pdf** on the CMS website.

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

CMS News Flash (GEN)

Are you billing correctly for ordered/referred services? Will you be impacted when CMS turns on the edits for these services? See the revised MLN Matters® articles **#SE1221**, **#SE1011**, and MLN fact sheets "***Medicare Enrollment Guidelines for Ordering/Referring Providers***" and "***The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement***" to learn what you need to do.

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

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

Has Medicare sent you a notice to revalidate your enrollment? If you are not sure, you can find lists of providers sent notices to revalidate their Medicare enrollment by scrolling to the "Downloads" section at **http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp** on the Centers for Medicare & Medicaid Services (CMS) website. That site currently contains links to lists of providers sent notices from September, 2011 through January, 2012. Information on revalidation letters sent in February will be posted in late March. For ease of reference, the lists are in order by National Provider Identifier and the date the notice was sent.

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

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

REVISED product from the Medicare Learning Network® (MLN)

- "*How to Protect Your Identity Using the PECOS*," Fact Sheet, ICN 905103, Downloadable only **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_ProtID_FactSheet_ICN905103.pdf**
- "*Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy - Protecting Your Medicare Enrollment Record*," Fact Sheet, ICN 903765, Downloadable only **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnrollPrivacy_Factsheet_ICN903765.pdf**
- "*Medicare Secondary Payer (MSP) Fact Sheet*," Fact Sheet, ICN 006903, Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MSP_Fact_Sheet.pdf**

- "*Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B*," Booklet, ICN 006266, Downloadable **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf**
- "*The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers Fact Sheet*," ICN 904283, Downloadable only **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf**

The 2013 ICD-10-PCS files have been posted on the 2013 ICD-10 PCS and GEMs web page. This includes the 2013 Index and Tabular files, guidelines, code titles, addendum to reference manual, and slides. The 2013 ICD-10-PCS files contain information on the new procedure coding system, ICD-10-PCS, that is being developed as a replacement for ICD-9-CM, Volume 3. The "*2013 General Equivalent Mappings (GEMs), Reimbursement Mappings, and Reference Manual*" will be posted at a later date.

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the General Equivalence Mappings (GEMs) at **http://www.cms.gov/Medicare/Coding/ICD10/index.html** on the ICD-10 website. See the links on that page for 2011 ICD-10-CM and GEMs, and 2011 ICD-10-PCS and GEMs. In addition, CMS has also posted a document, "ICD-10 GEMs 2011 Version Update, Update Summary." This document describes the number of comments CMS received, the type of changes recommended, the types of changes made based on the comments, the types of comments not accepted, and the reasons why some comments were not accepted.

Under the Affordable Care Act, Medicare beneficiaries may now receive coverage for an Annual Wellness Visit (AWV), which is a yearly office visit that focuses on preventive health. In addition, Medicare also provides coverage for the Initial Preventive Physical Examination (IPPE), commonly known as the "Welcome to Medicare" visit. To learn more about the AWV and the IPPE, please refer to the CMS Medicare Learning Network® publication at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/mps_guide_web-061305.pdf** on the Centers for Medicare & Medicaid Services (CMS) website.

When billing Medicare, Home Health Agencies (HHAs) must use the individual National Provider Identifier (NPI) of the physician who orders/refers services, not the NPI of the physician's group practice. If an HHA asks for your NPI, be sure to provide your individual NPI. Don't know your individual NPI? You may verify your NPI on the **NPI Registry** on the CMS website.

CMS e-News (GEN)

CMS has begun sending informational messages to contractors via a new link called "e-News". This is a pilot format that CMS is testing from August 1st - September 30th.

The e-News is an official Medicare Learning Network® (MLN) branded CMS product that contains a week's worth of news for Medicare Fee-for-Service (FFS) providers. It delivers planned, coordinated messages on Medicare-related topics. CMS sends the e-News electronically on a weekly basis. CMS will continue to send standalone e-News items for time sensitive information that cannot wait until the next edition.

NHIC, Corp. has begun sending CMS messages in this new link format. Suppliers will need to follow the link to view all the pertinent CMS news and articles for the week. The first e-News link is listed below. For the duration of the pilot, CMS Messages will be posted on our web site in this new e-News format.

CMS e-News for Wednesday, August 1, 2012

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-01Enews.pdf

This e-News edition contains the following messages of interest to DME Suppliers:

- Effective Today August 1, Medicare to Automatically Convert Format 4010A1 Electronic Remittance Advice (835) to X12 Version 5010
- Prior Authorization of Power Mobility Devices Demonstration to Begin September 1

- CMS Announces Provider Compliance Interactive Map
- Assembling an ICD-10 Project Team
- Get Ready for DMEPOS Competitive Bidding
- From the MLN: "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet - Revised
- Medicare Learning Network® Exhibit Schedule

This e-News edition contains the following Urgent and Time Sensitive messages:

- Corrections to Skilled Nursing Facility (SNF) Consolidated Billing File for Healthcare Common Procedure Coding System (HCPCS) Code J9033
- Prior Authorization of Power Mobility Devices Demonstration to Begin September 1
- Effective August 1, Medicare to Automatically Convert Format 4010A1 Electronic Remittance Advice (835) to X12 Version 5010

CMS e-News for Wednesday, August 8, 2012

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-08Enews.pdf

This e-News edition contains the following messages of interest to DME Suppliers:

- Get Ready for DMEPOS Competitive Bidding

CMS e-News for Wednesday, August 15, 2012

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-15Enews.pdf

This e-News edition contains the following messages of interest to DME Suppliers:

- Major Improvements to the Internet-based PECOS System
- Get Ready for DMEPOS Competitive Bidding
- "Addition of Digital Document Repository to Provider Enrollment Chain and Ownership System (PECOS)" MLN Matters® Article - Released
- "Important Update Regarding 5010/D.0 Implementation - Action Needed Now" MLN Matters® Article - Reminder
- New MLN Provider Compliance Fast Fact
- Be Part of the MLN Creative Process - Volunteer Now

CMS e-News for Wednesday, August 22, 2012

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-22e-News.pdf

This e-News edition contains the following messages of interest to DME Suppliers:

- Develop Your ICD-10 Communication and Awareness Plan
- Act Now to Avoid Claim Denials for Ordered/Referred Services
- All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer
- January 2013 Edit Spreadsheet Changes
- August 2012 Version of Medicare Learning Network® Products Catalog Now Available
- "Addition of Digital Document Repository to Provider Enrollment Chain and Ownership System (PECOS)" MLN Matters® Article - Released
- New Enhancements to the MLN Product Ordering System
- New Continuing Education Association Now Accepting Medicare Learning Network® (MLN) Courses
- "CMS Website Wheel" Educational Tool - Reminder
- "Medicaid Program Integrity: Safeguarding Your Medical Identity" Educational Products - Released

This e-News edition contains the following Urgent and Time Sensitive messages:

- January 2013 Edit Spreadsheet Changes

CMS e-News for Wednesday, August 29, 2012

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-08-29-e-News.pdf

This e-News edition contains the following messages of interest to DME Suppliers:

- New Health Care Standards to Save up to $6 Billion
- HHS Secretary Kathleen Sebelius Announces Compliance Date for ICD-10
- Now Available: New Webcast for Round 1 Recompete Bidders
- "Important Reminder About Medicare Secondary Payer Laws" MLN Matters® Article - Released
- "Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs)" MLN Matters® Article - Released

CMS e-News for Wednesday, September 5, 2012

http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2012-09-05e-News.pdf

This e-News edition contains the following messages of interest to DME Suppliers:

- September is National Cholesterol Education Month
- Influenza Season is Around the Corner
- Registration Reminder for DMEPOS Competitive Bidding
- New Comparison Tables Highlight the Differences Between the Two Stages of Meaningful Use
- Medscape Modules Available on ICD-10
- Now Available: New Email Updates for Those Who Refer Medicare Beneficiaries for DMEPOS
- "Medicare Claim Submission Guidelines" Fact Sheet - Revised
- Medicare Learning Network® Exhibit Schedule

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:

- 3rd Quarter 2012 Jurisdiction A DME MAC Fee Schedule
- 3rd Quarter 2012 Average Sales Price Medicare Part B Drug Pricing File
- 3rd Quarter 2012 Oral Anticancer Drug Fees

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

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

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

DME MAC Jurisdiction A Local Coverage Determinations (GEN)

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

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

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Correct Coding for Oral Appliances for the Treatment of Obstructive Sleep Apnea (E0486) (SPE)

Recently questions have arisen about reimbursement for custom fabricated oral appliances coded as E0486 (ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT). Only oral appliances used for the treatment of obstructive sleep apnea (OAOSA) that meet the durable medical equipment (DME) statutory benefit category requirements are eligible for Medicare reimbursement by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All requirements of the definition must be met before an item can be considered to be DME (CMS IOM 100-2, Ch. 15, §100). Oral devices that do not meet the DME benefit criteria are classified as dental appliances and are not eligible for reimbursement under the DME benefit by the DME MACs.

Since the OAOSA Local Coverage Determination first became effective in January 2011, numerous devices have been submitted to the Pricing, Data Analysis and Coding (PDAC) contractor for inclusion into HCPCS code E0486. Many of these items vary significantly from the characteristics of the predicate product upon which the initial benefit category determination and subsequent HCPCS code were developed. The coding guidelines for OAOSA contained in the Oral Appliances for Obstructive Sleep Apnea Local Coverage Determination related Policy Article describe the requirements that must be met for an OAOSA to be classified as DME and coded as E0486. Based on the wide variety of products that have been submitted for review, the DME MACs are revising the coding guidelines to provide more detailed and specific information to assist with product classification.

Effective July 1, 2012 the coding guidelines for OAOSA items coded as E0486 are revised to state:

> A custom fabricated oral appliance (E0486) is one which is individually and uniquely made for a specific patient. It involves taking an impression of the patient's teeth and making a positive model of plaster or equivalent material. Basic materials are used with the positive model to produce the final product. Custom fabrication requires more than trimming, bending, or making other modifications to a substantially prefabricated item. A custom fabricated oral appliance may include a prefabricated component (e.g., the joint mechanism).
>
> Code E0486 may only be used for custom fabricated mandibular advancement devices. To be coded as E0486, custom fabricated mandibular advancement devices must meet all of the criteria below:
>
> - Have a fixed mechanical hinge (see below) at the sides, front or palate; and,
> - Be able to protrude the individual beneficiary's mandible beyond the front teeth when adjusted to maximum protrusion; and,
> - Incorporate a mechanism that allows the mandible to be easily advanced by the beneficiary in increments of one millimeter or less; and,
> - Retain the adjustment setting when removed from the mouth; and,
> - Maintain the adjusted mouth position during sleep; and,
> - Remain fixed in place during sleep so as to prevent dislodging the device; and,
> - Require no return dental visits beyond the initial 90-day fitting and adjustment period to perform ongoing modification and adjustments in order to maintain effectiveness (see below)

A fixed hinge is defined as a mechanical joint containing an inseparable pivot point. Interlocking flanges, tongue and groove mechanisms, hook and loop or hook and eye clasps, elastic straps or bands, etc. (not all-inclusive) do not meet this requirement.

Items that require repeated adjustments and modification beyond the initial 90-day fitting and adjustment period in order to maintain fit and/or effectiveness are not eligible for classification as DME. These items are considered as dental therapies, which are not eligible for reimbursement, by Medicare under the DME benefit. They must not be coded using E0486.

Custom fabricated mandibular advancement devices that do not incorporate all of the criteria above must be coded as A9720.

Effective July 1, 2012 all product submissions will be reviewed using these coding guidelines. All products currently listed on DMECS must be re-reviewed and will be evaluated based on these requirements by the PDAC. The PDAC will not require a resubmission of applications for products that have already been coded and listed on DMECS. Current file information will be used for this re-review. Effective November 1, 2012, only those products that have been re-reviewed through the PDAC coding verification review process and listed as code E0486 on the PDAC Durable Medical Equipment Coding System (DMECS) web site may use this code. All unlisted devices must use HCPCS code A9270 (NON-COVERED ITEM OR SERVICE).

The PDAC DME and Supplies coding verification application required for these products is located on the PDAC website at: **https://www.dmepdac.com/review/apps_check.html**. Coding decisions are updated frequently. Suppliers should refer to the Product Classification List often to ensure that items billed have been coded by the PDAC. The Product Classification List in DMECS is located on the PDAC web site at: **https://www.dmepdac.com/dmecs/index.html**

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**

Refer to the Local Coverage Determination, related Policy Article and *Supplier Manual* for additional information.

FAQ - Refill Requirements for Non-consumable Supplies (GEN)

In 2011, CMS added sections to the *Program Integrity Manual* (Internet Only Manual 100-8) Chapter 5 establishing the requirements for the provision of refills of supplies effective 8/2/2011. The DME MACs published a bulletin article announcing these new requirements along with guidance for documenting compliance. These requirements are applicable to all DMEPOS items and supplies provided on a recurring basis.

A key element of these requirements is the supplier's responsibility to monitor utilization of supplies and only provide a refill when the beneficiary's supply on hand is "approaching exhaustion". Given the range of products affected by this requirement, numerous inquiries were received asking for specifics about how to assess for this criterion. In June 2012, a revised bulletin was published by the DME MACs with documentation guidance to address this issue. This FAQ addresses questions about the June 2012 bulletin.

Q1: **Why separate consumable items from more durable ones?**

A: Separating consumable from non-consumable supplies was based on calls from suppliers and inquiries received from our respective Provider Outreach and Education representatives at webinars and seminars. Specifically suppliers were asking, in light of the refill requirements in the LCD requiring suppliers to determine "…existing supplies are approaching exhaustion", how should suppliers document "approaching exhaustion" for items that are "used up" (e.g., diabetic test strips) versus items that are no longer functional (e.g., PAP and RAD supplies). Based on the questions, it made sense to segregate those two types of items in the documentation section.

Q2: Some DME items like infusion pumps and enteral and parenteral nutrition pumps also have non-consumable items as supplies. What items are considered to be durable or non-consumable supplies?

A: Supplies used with RAD and PAP devices and mastectomy bras were the initial supply items identified as non-consumable or durable and not requiring routine, scheduled replacement. Some items such as external infusion pumps or enteral and parenteral nutrition pumps have supplies provided in all-inclusive supply kit allowances. These supply kit allowances are considered payable as noted in the applicable local coverage determinations (LCDs) to cover all costs of supplies necessary for effective use of the base product.

Q3: Why is it necessary to monitor utilization for durable supplies?

A: The DMDs recognize that providers of durable or non-consumable supplies are not accustomed to monitoring the utilization and condition of these items; however, the *Program Integrity Manual* (PIM) §5.2.6 refill requirements preclude the automatic dispensing (refill) of any supply item. All items and supplies provided on a recurring basis must be monitored and only replaced when replacement is genuinely needed.

Q4: Why are the documentation guidelines for non-consumable items so vague?

A: We understand that many suppliers would prefer explicit, prescribed instructions. The DMDs deliberately did not provide specific guidance as to how a supplier might assess the need for replacement of non-consumable supplies leaving as much flexibility to the supplier's discretion as possible. The PIM §5.2.6 refill requirement requires a determination that the need for the refill is justified. Recognizing that there are differing products and business practices, allowing each supplier to decide how to best assess and document the need for replacement was the most appropriate course.

Q5: Explain what is meant by the term "non-functional".

A: For purposes of this requirement, non-functional means that the item is no longer able to be used safely or effectively for the purpose for which it was intended. There are numerous reasons that would render durable supplies non-functional. Breakage, wear, or contamination (not all-inclusive) are some common examples. When the item becomes unusable for reasons such as damage, wear, soiling or contamination that is unable to be removed with recommended cleaning, etc., the item can be considered as nonfunctional and may be replaced. All problems with the proper function of an item may not justify replacement (refill) of the item. For example, contrast the above situations with problems with function caused by improper fit or incorrect use such as might occur with a CPAP mask leak. Mask leak may be due to a non-functioning mask OR an ill-fitting or incorrectly worn interface. The latter would not necessitate replacement but rather reassessment of fit and possible adjustment by the physician or supplier.

Q6: What about maintenance or care for the item?

A: Appropriate replacement (refill) assumes reasonable effort to maintain the items per the manufacturer's instructions. With basic care these items remain useable and uncontaminated for extended periods. For example, we all recognize that improper or neglected care can render items dirty and contaminated; however, the solution is proper care and cleaning, not frequent replacement. As noted above, when the item becomes unusable for reasons such as damage, wear, soiling or contamination that is unable to be removed with recommended cleaning, etc., the item can be considered as nonfunctional and may be replaced.

Q7: What is the effective date of the revision? The article says 8/2/11 - is this retroactive?

A: The documentation guidance is effective 8/2/11. These clarifications are not new requirements but simply provide additional explanations of the existing requirements that were published in August 2011, concurrent with the PIM §5.2.6 addition. This PIM section makes no distinction between supplies that are "used up" and those that are not. The PIM requires an assessment of whether or not supplies are "approaching exhaustion" and requires that suppliers not automatically ship new supplies. The June 2012 bulletin revision is an explanation of how to apply the existing "approaching exhaustion" requirement to non-consumable items.

Q8: Why are so many new requirements being published?

A: As part of our error reduction strategies, the DME MAC Medical Directors have begun including explicit statements about long-standing Medicare payment rules in many policies. Previously these requirements were only found in our DME MAC *Supplier Manual* and/or in CMS publications. Lack of familiarity with these requirements often leads to complaints that "new" and "more restrictive" rules have been put in place when the only thing new is a heightened awareness of the existing applicable payment policy. The refill guidance is one example of this.

Q9: Must the supplier physically inspect the item?
A: It depends on the problem reported. Some issues may require physical inspection by the supplier while others may be resolved through instructions to the beneficiary for adjustment or other accommodations.

Q10: Can the cleanliness state of the item be a reason to deem it non-functional (patient has not followed cleaning instructions and the part is now questionable from a health standpoint, even with a thorough cleaning)?
A: Yes, once the supplier determines that the item is no longer functional. Suppliers are reminded that they are responsible for instructing the beneficiary in the proper cleaning and care of the equipment and supplies.

Q11: What documentation must be created to ensure that the claim would pass an audit?
A: Document the reason(s) the item is no longer functional.

Q12: How does this revision affect the provision of a three-month supply?
A: Non-consumable supplies may be replaced when they are non-functional. The usual maximums listed in the LCD should not be construed as a routine or automatic replacement schedule or amount. If an item is still working and in good condition, there is no need to replace it. For example, many of the accessories/supplies used with positive airway pressure (PAP) devices do not require routine replacement at the "usual maximum" frequency listed in the LCD if cleaned and maintained according to the manufacturer's recommendations. Suppliers are required to confirm and document the amount and condition of supplies before sending out replacements.

Q13: Does this bulletin change the utilization guidelines in the LCD?
A: The guidance does not change the usual maximums or the replacement frequencies outlined in the LCD. It simply reiterates what has been published in the past by the DME MACs and CMS about replacements. Replacement is not automatic and suppliers need to assess and document the quantity and/or condition of the remaining supply. If it's something used up, ask how much is left. If it's something that can stop working effectively, ask about those common things that indicate it's not working effectively.

Q14: Under this provision, if the item becomes dysfunctional PRIOR TO the old "replacement schedule," will the replacement part be covered?
A: It may be. As noted in the questions above, assuming the non-functional status is not due to a correctable issue (e.g., fitting, adjustment, improper use), when a durable supply becomes non-functional, it is eligible to be replaced. If this results in exceeding the usual maximum allowable outlined in the LCD, suppliers should have sufficient documentation to explain why the amount exceeds the usual maximum supplies.

Q15: During the trial period, it is not unusual for a patient to need a different mask after trying one and it being "dysfunctional." Will Medicare pay for a new mask under this condition?
A: No. The mask is still functional, just not appropriate for that patient. It is a long-held position that Medicare will only pay for a replacement when the item is non-functional.

Items Provided on a Recurring Basis and Request for Refill Requirements - Revised - August 2012 (GEN)

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. CMS has revised the requirements for refills effective for dates of service on or after August 2, 2011.

August 2012 Revision

This revision updates the original article. Changed:

- Revision of the Billing Frequency section to restore historical billing frequency for drugs and supplies used with external infusion pumps, including external insulin pumps.

June 2012 Revision

This revision updates the original article. Changes include:

- Revised refill documentation instructions regarding consumable and non-consumable supplies
- Addition of External Breast Prosthesis LCD to the list of included policies

Requirements

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

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

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

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

Documentation Requirements

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

- There is a change of supplier
- There is a change in 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 patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

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

- Beneficiary's name or authorized representative if different from the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) - The Supplier should assess the quantity of each item that the beneficiary still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., Positive Airway Pressure and Respiratory Assist Device supplies) - The supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

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

Billing Frequencies

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

For all other refills that are provided on a recurring basis suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous

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

- Automatic External Defibrillators
- Enteral Nutrition
- External Breast Prosthesis
- External Infusion Pumps
- Glucose Monitors
- Immunosuppressive Drugs
- Intravenous Immune Globulin
- Nebulizers
- Negative Pressure Wound Therapy
- Oral Anticancer Drugs
- Oral Antiemetic Drugs
- Ostomy Supplies
- Oxygen (for billable contents)
- Parenteral Nutrition
- Positive Airway Pressure Devices
- Respiratory Assist Devices
- Suction Pumps
- Surgical Dressings
- Tracheostomy Supplies
- Transcutaneous Electrical Nerve Stimulator (TENS)
- Urological Supplies

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

This August 2012 revision replaces the June 2012 revision of the original article. The original article, published August 2011, replaces the articles "*Request for Refill - Documentation Requirements*," published in September 2010 and "*Dispensing DMEPOS Items: Quantity Limits*" published in June 2007.

The June 2012 revision replaces the version published in August 2011.

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

LCD and Policy Article Revisions - Summary for August 31, 2012 (GEN)

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

Glucose Monitors

LCD

Revision Effective Date: 11/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Format and layout of basic coverage and high utilization criteria
Revised: Order requirements language to specify a "detailed written order"
Revised: Word "Patient" to "Beneficiary"
Clarified: Coverage of laser lancing devices and lens shield cartridges

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

Revised: Prescription requirements
Added: Documentation of beneficiary training

Tracheostomy Care Supplies

LCD

Revision Effective Date: 08/01/2012 (August Publication)

INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: UOS for A4456 from 1 to 50 (clerical correction from 1 box to the 50 units per box)

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

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

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

Ankle-Foot/Knee-Ankle-Foot Orthoses

Policy Article

Revision Effective Date: 07/01/2012 (July Publication)
CODING GUIDELINES:
Deleted: Coding verification for codes L1930, L1932, L1940, L1960, L1970 and L1971

Ostomy Supplies

LCD

Revision History Effective Date: 01/01/2012 (July Publication)
INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:
Revised: Order requirements language to specify a "detailed written order" (omitted in error from the last revision)
Added: Reference to Policy Article for information about the statutory coverage requirements for ostomy supplies
Added: Refill requirements per PIM 5.2.6 (effective 08/02/2011 per CR7452)
Added: Reference to information in Tracheostomy Care Supplies LCD
Added: POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Oral Appliances for Obstructive Sleep Apnea

LCD

Revision Effective Date: 07/01/2012
INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Denial Statement for tongue-retaining devices
Clarified: Projection of AHI/RDI calculations based upon less than 2 hours of testing time
Added: ACHC as accreditation entity for personnel interpreting sleep testing
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 and proof of delivery requirements

Policy Article

Revision Effective Date: 07/01/2012
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Section describing the general dental exclusion
CODING GUIDELINES
Revised: Coding for tongue retaining devices
Revised: Coding for E0486

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.*

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

Historical Review Results

A widespread complex medical review was performed for Lower Limb Prostheses HCPCS codes billed with a K3 functional level modifier and components/additions provided. This review resulted in a Charge Denial Rate (CDR) of 90.9%. A summary of findings was published on the NHIC web site on April 20, 2012. Based on this result, a widespread prepayment review was continued.

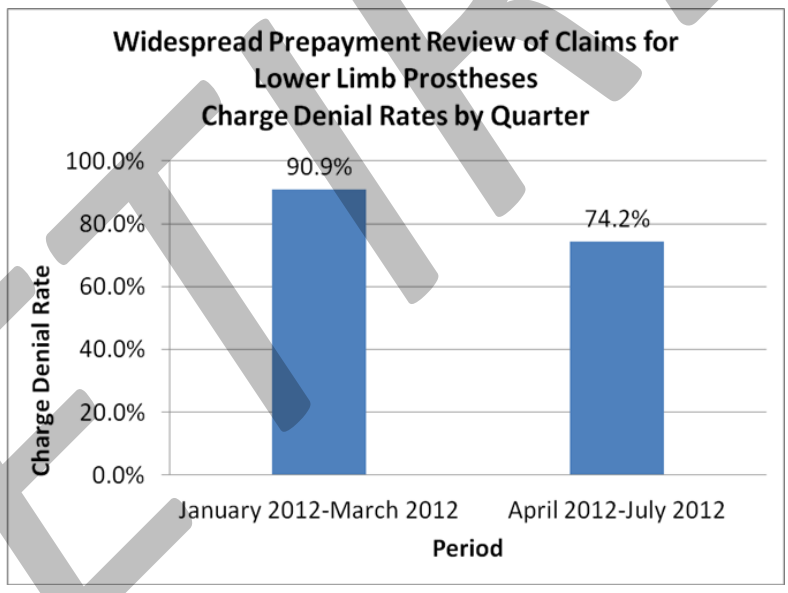
Current Review Results

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

The review involved prepayment complex medical review of 174 claims submitted by 128 suppliers for claims processed March 2012 to June 2012. Responses to the Additional Documentation Request (ADR) were not received for 20 (11%) of the claims. For the remaining 154 claims, 37 claims were allowed and 117 were denied resulting in a claim denial rate of 76%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error divided by the total allowance amount of services medically reviewed) resulted in an overall Charge Denial Rate of 74.2%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Lack of Medical Record Documentation

- 57% of the denied claims were missing the clinical documentation to corroborate the prosthetist's records and support medical necessity.

Evaluation/assessment documentation

- 7% of the denied claims were missing the evaluation/assessment documentation for the functional level of item(s) billed (prosthetist assessment).

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

- 22% of the denied claims had clinical records that did not justify the functional level of the billed item.

Proof of delivery

- 1% of the denied claims were missing the proof of delivery.

Claim Examples

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

Example 1:

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

Example 2:

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

Example 3:

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

Next Step

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

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

Educational References

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

- LCD for Lower Limb Prostheses (L11464) and related Policy Article (A25310)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

- The DME MAC Jurisdiction A *Supplier Manual*
  http://www.medicarenhic.com/dme/suppmandownload.shtml
  - Chapter 10: includes information regarding documentation requirements

- Dear Physician Letter - Documentation of Artificial Limbs
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/phy_letter_artificial_limbs.pdf

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

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

- Results of Widespread Prepayment Complex Review for Lower Limb Prostheses - Posted April 20, 2012
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/042012_llp.pdf

- Results of Widespread Prepayment Probe for Lower Limb Prostheses - Posted November 30, 2011
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/113011_llp.pdf

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Results of Widespread Prepayment Probe 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 included 386 claims from October, 2011 through December, 2011 and resulted in a 67.6% Charge Denial Rate (CDR).

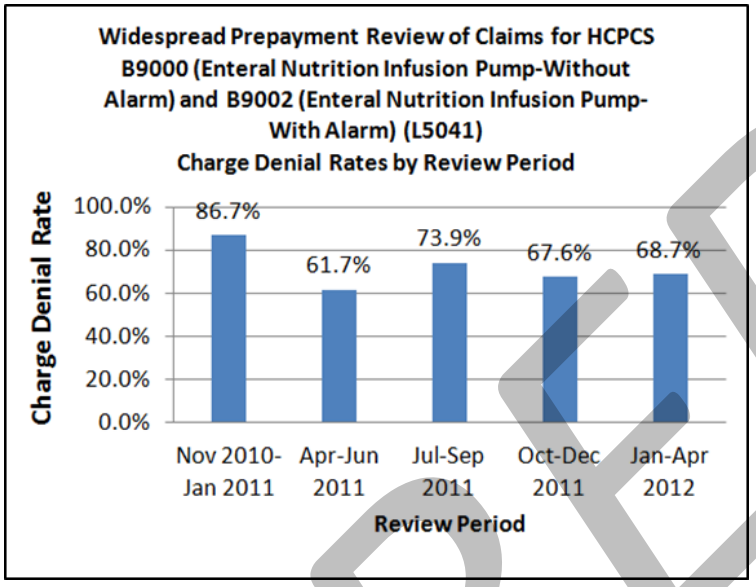
Current Review Results

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 409 claims processed primarily from January 01, 2012 through April 30, 2012.

The review involved prepayment complex medical review of 409 claims submitted by 123 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 126 (31%) of the claims. For the remaining 274 claims, 87 claims were allowed and 187 were denied/partially denied resulting in a claim denial rate of 68.2%. 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 68.7%.

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

- 11.6% of the denied claims had insufficient clinical documentation to justify the LCD criteria needed for one or both of the following for enteral nutrition.
  - (a) a permanent non-function or disease of the structures that normally permit food to reach the small bowel (b) a disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status.)
  - **Note:** *The criteria for enteral nutrition must first be met in order to allow consideration for payment of an enteral nutrition infusion pump.*
- 16% of the denied claims did not have any medical record documentation submitted

Proof of Delivery Issues

- 10.2% of the denied claims had no Proof of Delivery
- 5.5% of delivered equipment was delivered before MD detailed order was signed and dated

Detailed Written Order issues

- 4.8% of the denied claims had missing detailed written orders
- 12.5% of the denied claims had an incomplete detailed written orders
  - Date of the detailed order was incomplete
  - MD signature could not be authenticated

DME MAC Informational Form (DIF) Discrepancies

- 4.8% of the denied claims were missing a DIF

Claim Examples

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

Example 1:

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

Example 2:

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

Example 3:

Received: DIF and Delivery ticket
Missing: From MD detailed written order, clinical records to support coverage for enteral nutrition and /or the enteral infusion pump per LCD L5041 requirements.

Next Step

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

Educational References

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

- Enteral Nutrition (L5041) LCD and Related Policy Article (A26229)
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

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

- Results of Widespread Prepayment Review for B9000 (Enteral Nutrition Infusion Pump-Without Alarm) and B9002 (Enteral Nutrition Infusion Pump-With Alarm) (L5041) (issued 9/30/2011)
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_pca/093011_enteral.pdf

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

- 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 September 2011 through January 2012 and resulted in a Charge Denial Rate (CDR) of 60.2%.

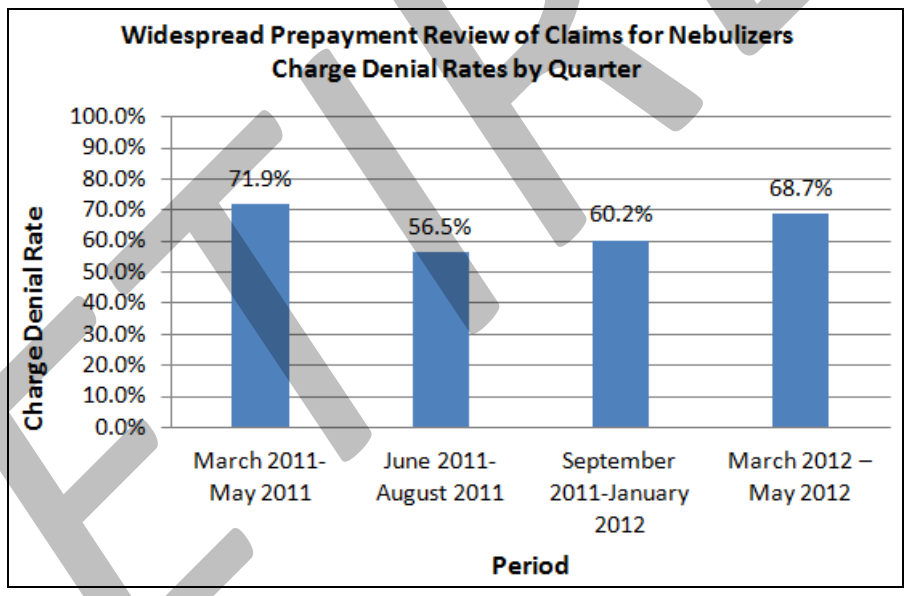
Current Review Results

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

The review involved prepayment complex medical review of 870 claims submitted by 338 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 315 (45%) of the claims. For the remaining 555 claims, 250 claims were allowed and 305 were denied/partially denied resulting in a claim denial rate of 55 %. 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 68.7%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Clinical Documentation Issues

- 75.5% of the denied claims were missing any clinical information to support medical necessity. No medical records of any sort were submitted.
- 7% of the denied claims had insufficient clinical documentation. The documentation submitted focused on other medical issues unrelated to nebulizers.

Detailed Written Order Issues

- 9% of the denied claims were missing the detailed written order.

Proof of Delivery Issues

- 12% of the denied claims were missing proof of delivery.

Claim Examples

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

Example 1:

Received: Detailed physician's order with legible signature and date of signature, delivery ticket including recipients/caregiver signature and date of receipt and payable diagnosis.
Missing: Clinical records demonstrating reasonable and necessary use of nebulizer equipment.

Example 2:

Received: Claim received with clinical records from MD, delivery ticket including recipients/caregiver signature and date of receipt and payable diagnosis.
Missing: Detailed written order with beneficiary name, description of item to be dispensed, ordering physician' legible signature, and date of physician signature

Example 3:

Received: Detailed written order with beneficiary name, physician's legible signature and date of signature, clinical records and payable diagnosis
Missing: Proof of delivery including recipient/caregiver signature and date of receipt.

Next Step

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

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

Educational References

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

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

- Results of Widespread Prepayment Review of Claims for E0570: November 11, 2010, March 25, 2011, July 1, 2011, December 22, 2011, and April 20, 2012.
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

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

- CERT Physician Letter - Nebulizers Monthly CERT Error examples (April 2011, May 2011, July 2011, January 2012, February 2012, and May 2012)
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml

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

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

Historical Review Results

DME MAC A Medical Review continues to review Continuous Positive Airway Pressure Devices, HCPCS E0601, based on the results of the previous review findings. The previous quarterly findings covered claims reviewed from November 2011 through January 2012 and resulted in a 53.5% Charge Denial Rate (CDR).

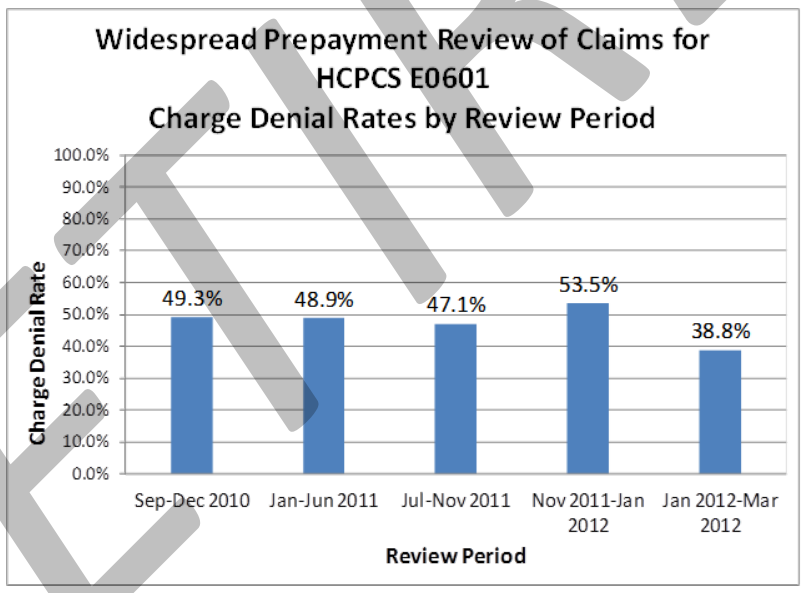
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Continuous Positive Airway Pressure Devices (HCPCS E0601). These findings include claims processed from January 2012 through March 2012. This review continues based upon the high CDR reported from the previous quarter.

This review involved prepayment complex medical review of 616 claims submitted by 291 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 66 (10%) of the claims. Of the 616 claims for which responses were received, 351 claims were allowed and 199 were denied/partially denied. This resulted in a claim denial rate of 36%. 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 38.8%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

Based on 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

- 50.3% of the denied claims were missing required clinical documentation and medical records to support medical necessity. Consequently they did not meet the coverage criteria outlined in the PAP Local Coverage Determination.
    - These claims had no Face to Face clinical evaluations from the beneficiaries' medical records. Included in these were no Face to Face clinical evaluations conducted by the treating physician where the beneficiaries were seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare

- 17.4% of the denied claims had insufficient clinical documentation to support medical necessity and consequently did not meet the coverage criteria outlined in the PAP Local Coverage Determination. The insufficient clinical documentation included:
    - Clinical documentation provided did not reflect the need for the care provided. No detailed narrative in the clinical documentation describing presenting symptoms of sleep disordered breathing, daytime sleepiness/fatigue, observed apneas, and/or choking/gasping during sleep; duration of symptoms; or Epworth Sleepiness Scale scores (the sleep hygiene inventory).
    - Face to Face clinical re-evaluation failed to demonstrate improvement in OSA symptoms and beneficiary continued benefit from sleep therapy.
    - Insufficient clinical documentation noted in Face to Face evaluations conducted by the treating physician in claims where the beneficiary is seeking PAP replacement following the 5 year RUL or when requesting coverage of a replacement PAP upon entering FFS Medicare
- 3.9% of the denied claims were missing the MD signature on the Face to Face clinical evaluation.
- Less than 1% of the denied claims had illegible Face to Face documents.

Detailed Written Order Issues

- 4.1% (or 12) of the denied claims did not include the MD Detailed Written Order.
- 1% (or 3) of the denied claims failed to either list all items separately billed or refill/replacement instructions.
- 0.3% (or 1) of the denied claims had Detailed Written Orders that were illegible.
- 0.7% (or 2) of the denied claims had Detailed Written Orders that were not dated by the treating physician.

Sleep Study Documentation Issues

- 7.6% of the denied claims did not include a copy of the original Medicare covered Sleep Study.
- 2.1% of the denied claims had sleep study documents that did not meet coverage criteria per the PAP LCD.
- 9.7% of the denied claims had no practitioner's signature on the Medicare approved Sleep Study interpretation per the PAP LCD.

Training Documentation Issues

- 26% of the denied claims did not include evidence of training on the PAP device.
- 0.3% of the denied claims did not include evidence of beneficiary training (by sleep technician) on how to properly apply a portable sleep monitoring device prior to testing for sleep apnea in the home setting. Per the PAP LCD, this can be accomplished either by a face to face demonstration, via video, or telephonic instruction and noted in the record.

Delivery Issues

- 9.0% of the denied claims were missing Proof of Delivery.
- 2.8% of the denied claims were missing billed items on the Proof of Delivery.

ABN Issues

- 0.3% of the denied claims mentioned above included Medicare Waiver of Liability forms that did not meet the criteria for ABN validity for Complex Medical Record Reviews. These documents are not an acceptable substitute for the current ABN; reference CMS-R-131(03/11) Form.

Claim Examples

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

Example 1:

Received: Included in this claim was proof of delivery, evidence of training on the PAP device, a Face to Face clinical evaluation, a Medicare approved Sleep Study, and an MD Detailed Written Order form for the PAP device.

Missing: Medicare requires that services provided be authenticated by the treating practitioner. There was no real or electronic signature or attestation statement found on the Face to Face clinical evaluation by the treating practitioner. There was also no real or electronic signature found on the Sleep Study by the prescribing practitioner. This claim did not meet the signature requirements found in the DME MAC Jurisdiction A *Supplier Manual*.

Example 2:

Received: Included in this claim was proof of delivery, evidence of training on the PAP device, MD Detailed Written Order, and a copy of the original Home Sleep Study.

Missing: This claim is missing a Face to Face clinical evaluation by the treating practitioner prior to the Sleep Study that addresses evidence of current symptoms of a sleep disorder including but not limited to snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches, or a valid Epworth sleepiness scale. This claim is also missing the required training prior to taking a Home Sleep Study demonstrating that they received verbal/phone/video instruction on how to properly apply a portable sleep monitoring device.

Example 3:

Received: Included in this claim are a Face to Face clinical evaluation, a Medicare approved Sleep Study, and an MD Detailed Written Order.

Missing: This claim is missing proof of delivery that the beneficiary received the items prescribed by the physician. The claim is also missing evidence of training demonstrating the beneficiary 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.

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

Educational References

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

- Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L11528) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

- Results of Widespread Prepayment Review of Claims for Continuous Positive Airway Pressure Devices (E0601): Posted 04/20/2012, 12/22/2011, 08/19/2011, 3/4/2011 and 07/02/2010
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_pca.shtml

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

- CERT Physician Letter - Positive Airway Pressure (PAP) Devices
  http://www.medicarenhic.com/dme/CERT/CERT_phy_letter_pap.pdf

- CERT Documentation Checklist
  http://www.medicarenhic.com/dme/articles/050109_certchecklist.pdf

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

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

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

Historical Review Results

DME MAC A Medical Review continues to review Power Wheelchairs, HCPCS K0823, based on the results of previous quarterly findings. The previous quarterly findings covered the period from October 01, 2011 through December 31, 2011 resulted in a 49.8% percent Charge Denial Rate (CDR).

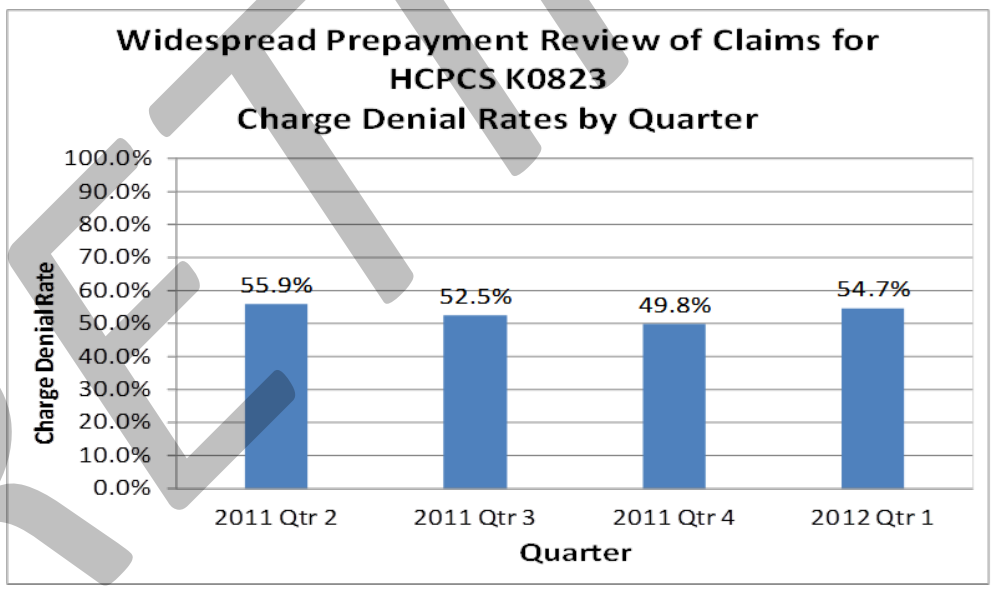
Current Review Results

DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Power Wheelchairs (HCPCS code K0823). These findings include claims with dates processed from January 01, 2012 through April 30, 2012. This review was initiated due to errors identified by the Comprehensive Error Rate Testing (CERT) Contractor.

This review involved prepayment complex medical review of 711 claims submitted by 225 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 108 (15%) of the ADR requests issued. Of the claims for which responses were received, 281 (47.3%) of the claims were allowed and 313 (52.7%) of the claims were denied. This resulted in a claim denial rate of 52.7%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 54.7%.

Charge Denial Rate Historical Data

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



Primary Reasons for Denial

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

Insufficient Documentation (33%)

- 23% - Reasonable and Necessary issues include the following:

- Documentation available from the mobility exam is insufficient as it does not include a comprehensive face to face exam by the treating physician that objectively addresses mobility limitations and provide a clear picture of the patient's mobility deficits. Sufficient objective measurements were not provided.
- Face to Face record is a supplier generated form which the treating physician completed. No comprehensive narrative clinical documentation was received which reflects a clear understanding of the beneficiary's mobility with measured recordings of patient's upper and lower extremity strength and range of motion.

- 10% - Incomplete or missing documentation includes the following:
  - 5% - Face to Face exam was not included.
  - 3% - 7 Element F2F date did not match Face to Face performed by treating physician or in concurrence/disagreement of specialty exam.
  - 2% (total) for the following:
    - Illegible documentation.
    - Face to Face exam received, however, the document was incomplete due to either Face to Face exam not dated or signed by treating physician.
    - No treating physician signature in concurrence or disagreement with specialty exam.

7 Element Order Issues (23%)

- 15% - Incomplete 7 Element orders; missing one or more required elements.
- 4% - No 7 Element order.
- 2% - 7 Element orders which did not include confirmation the supplier received a copy within 45 days after the completion of the Face to Face exam; as verified by a supplier date stamp or equivalent.
- 2% (total) - for the following :
  - Illegible 7 Element order.
  - 7 Element order and detail product description were on the same form.
  - 7 Element Order dated prior to the Face to Face exam.

Detailed Product Description Issues (DPD) (14%)

- 11% - DPD not received.
- 3% (total)- For the following :
  - DPD dated before the 7 Element Order.
  - DPD did not match billed claim {impacted denial} K0823 was billed; K0840 on DPD.
  - DPD is dated after delivery of the PWC.
  - DPD does not match billed services.

Specialty Exam issues (19%)

- 19% - Documentation lacks financial attestation statement.

Home Assessment Issues (9%)

- 8% - Documentation did not include evidence of a home assessment being completed before or at the time of the delivery of the Power Wheel Chair, (PWC).
- 1% - Documentation of the denied claims were not signed and dated by either the supplier or the practitioner.

Delivery Ticket Issue (4%)

- 3% - No delivery ticket.
- 1% - Delivery ticket does not match claim date of service.

Claim Examples

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

Example 1: Date of Service 9/13/11, K0823

Received: Supplier cover sheet, supplier generated form (invoice), progress sheet (untitled), written order: (includes patient name, date, motorized wheelchair, use as needed, physician signature), various supplier generated forms, delivery ticket, supplier generated forms (medical necessity note and written order).

Missing: Complete 7 element order written by treating physician (patient name, motorized wheelchair, date of Face to Face exam, Length of need, treating physician signature and date), no detail product description, no home assessment, and no F2F exam.

Example 2: Date of Service 7/18/11, K0823

Received: Face to Face exam dated 6/9/11, treating physician note for need of motorized wheelchair, specialty exam 5/3/11 which is signed and dated by treating physician in concurrence of specialty exam, detail product description (appears to have 7 Element information also), confirmation of order, specialty evaluation, various supplier forms including beneficiary authorization, home assessment.

Missing: 7 Element order (detail product description and 7 Element order cannot be on same document). Valid delivery ticket; cannot authenticate signature on delivery ticket.

Example 3: Date of Service 10/27/11, K0823, E2365

Received: 7 Element order, detail product description, specialty exam, multiple clinical exams, home assessment, and valid delivery ticket.

Missing: Basic criteria in clinical documentation from treating or specialty exam to support patient meeting the basic criteria for a Power Wheelchair: Documentation did not address: mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living (MRADLs). The patient's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriate filled cane or walker. The patient does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day. Exam performed by licensed/certified medical professional (Occupational Therapist) did not include a financial attestation statement.

Next Step

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

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

Educational References

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

- CERT Error Articles
  http://www.medicarenhic.com/dme/dmerc_cert_rec.shtml
- Power Mobility Devices (L21271) LCD
  http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml
- Power Mobility Devices - 7-Element Order (published November 05, 2009).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletins/mr_bulletin_current/110509_7-element-order.pdf
- Power Mobility Devices Billing Reminder (published January 11, 2008).
  http://www.medicarenhic.com/dme/articles/011108_pmd.pdf
- DME MAC Jurisdiction A *Supplier Manual* (Chapter 10 - Durable Medical Equipment) for additional information regarding coverage and documentation requirements.
  http://www.medicarenhic.com/dme/suppmandownload.shtml
- Results of Widespread Prepayment Review of Claims for HCPCS K0823, (Power Wheelchair, Group 2 Standard, Captain's Chair, Capacity Up to and Including 300 Pounds) (published 4/20/12, published 12/15/11, published 08/26/11, published 6/10/11, published 3/11/2011, published 11/5/10).
  http://www.medicarenhic.com/dme/medical_review/mr_bulletin_current.shtml

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

- Power Mobility Devices (PMDs) Complying with Documentation & Coverage Requirements (Medicare Learning Network; ICN 905063 September 2011).
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf

- Power Mobility Device Face-to-Face Examination Checklist (SE1112).
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf

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

Historical Review Results

DME MAC A Medical Review continues to review Oxygen and Oxygen Equipment, based on the results of previous quarterly findings. The previous quarterly findings covered the period of October 01, 2011 through December 31, 2011 and resulted in a 42.7% Charge Denial Rate (CDR).

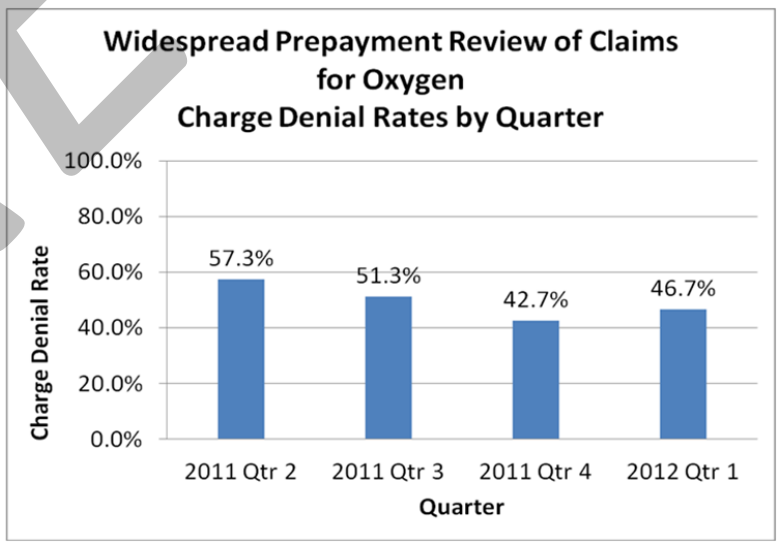
Current Review Results

The DME MAC Jurisdiction A has completed the widespread prepayment review of claims for Oxygen and Oxygen Equipment (E1390, E0431, and E0439). These findings cover claim process dates primarily from January 01, 2012 through March 31, 2012.

The review involved prepayment complex medical review of 818 claims submitted by 357 suppliers. Responses to the Additional Documentation Request (ADR) were not received for 186 (23%) of the claims. For the remaining 632 claims, 362 claims were allowed and 270 were denied resulting in a claim denial rate of 42.7%. The total denied allowance amount (dollar amount of allowable charges for services determined to be billed in error) divided by the total allowance amount of services medically reviewed resulted in an overall Charge Denial Rate of 46.7%.

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 (75%)

- 44% of the denied claims were missing a required treating physician visit - either prior to initial CMN or recertification CMN.
- 31% of the denied claims were missing both required treating physician visits - 30 days prior to the Initial CMN and prior to Recertification CMN.

Missing Documentation: (14%)

Required Certificate of Medical Necessity per LCD L11468 (7%)

- 4% Initial CMN.
- 3% Recertification CMN.

Other than required Certificate of Medical Necessity Forms (7%)

- 2% No documentation to validate oxygen testing.
- 5% No valid delivery ticket.

Clinical Documentation Issues: Medical Necessity could not be established per LCD L11468 (11%)

- 2% Patient did not meet criteria for Group 1 as indicated on CMN received for the following reasons:
  - Nocturnal testing did not qualify for Group 1 testing, less than 5 minutes recorded of desaturation.
  - Saturation testing upon hospital discharge does not qualify as none listed in progress note: discharge note: indicates pt achieves saturation @ 93% with 2L. Make arrangements for home oxygen if pt qualifies, otherwise will add Symbicort to inhaler regimen. No testing on RA included with documentation.
  - Medical documentation did not validate oxygen saturation level prior to initial CMN, no CMN received.
- 9% Miscellaneous other
  - Illegible documentation. (1)
  - Recommendation in clinical notes only states for use of hand held inhaler. (1)
  - 5 year replacement; required new initial CMN. (3)
  - 5 year replacement; required recertification CMN. (1)
  - Only Recertification CMN and delivery ticket received. (1)

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 10/20/11 code(s) billed: E0431, E1390

Documentation received: Initial CMN, Recert CMN, written physician order, valid delivery ticket, and assignment of benefits form.

Missing: Treating physician clinical notes to validate 30 days prior to initial CMN and w/in 90 days prior to recert CMN.

Example 2: DOS 11/27/11 code(s) billed: E0431

Documentation received: Telephone order dated 6/27/11, physician written order, treating physician clinical notes, Initial CMN dated 6/27/11, and valid delivery ticket.

Missing: No documentation of patient meeting Group 1 criteria as listed on CMN.

Example 3: DOS 07/12/11, code(s) billed: E1390

Documentation received: Telephone order, valid delivery ticket, Patient Education Form (supplier form), Initial CMN dated 7/12/11, treating physician written order.
Missing: Treating physician clinical notes, documentation to validate oxygen testing.

Next Step

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

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

Educational References

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

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

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

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

Supplier Replacement of Beneficiary-owned Capped Rental Equipment Based upon Accumulated Repair Costs (GEN)

Recently, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received inquiries about the Centers for Medicare & Medicaid Services' (CMS) Fact Sheet, *Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements*.

The Fact Sheet states:

> Under a special rule established for certain patient-owned equipment, such as a power wheelchair for which the title has been transferred to the patient after 13 continuous months of rental, the supplier must replace the equipment free of charge if it does not last the full 5-year period (i.e., is no longer serviceable or needs substantial repairs). This

> replacement equipment does not need to be 'new'. For more information, refer to 42 Code of Federal Regulations (CFR) Section 414.210(e)(4).

This passage references regulations that implemented the *Deficit Reduction Act of 2005* (DRA). This regulation stipulates that the supplier is responsible for replacement of a capped rental item if it is determined to be incapable of lasting for the entire 5 year reasonable useful lifetime. Replacement is provided at no cost to the beneficiary or to the Medicare program. 42 Code of Federal Regulations (CFR) Section 414.210(e)(4) states:

> (4) *Supplier replacement of beneficiary-owned equipment based on accumulated repair costs.* A supplier that transfers title to a capped rental item to a beneficiary in accordance with §414.229(f)(2)* is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if the carrier determines that the item furnished by the supplier will not last for the entire reasonable useful lifetime established for the equipment in accordance with §414.210(f)(1)**. In making this determination, the carrier may consider whether the accumulated costs of repair exceed 60 percent of the cost to replace the item.

* §414.229(f)(2) describes requirements for providing a capped rental item
** §414.210(f)(1) describes reasonable useful lifetime requirements

The default reasonable useful lifetime (RUL) of durable medical equipment (DME) is five years unless otherwise specified. Therefore, DME dispensed to Medicare beneficiaries is expected to remain in proper working condition throughout the required five year RUL. If it is determined based upon accumulated repair costs that the item is unable to last for the entire 5 year RUL, the supplier must replace the equipment with properly working equipment at no charge to the beneficiary or the Medicare program.

"Accumulated repair costs" refer to all repair claims from all suppliers for a given item after the rental period ends. These repair costs represent the total of all repair costs after the beneficiary has assumed ownership of the item.

The DME MACs encourage suppliers to provide DME items of sufficient quality to last for the entire 5 year RUL.

Refer to the *Supplier Manual* and/or the applicable Local Coverage Determination and related Policy Article for additional information on repairs and replacement.

Toe Fillers and Diabetic Shoe Inserts - Coding Clarification (O&P)

Questions have arisen about the correct coding for shoe inserts used to accommodate missing digits (toes) on feet for beneficiaries with and without diabetes. These items fall under two separate benefit categories and use two distinct Healthcare Common Procedure Coding System (HCPCS) codes, L5000 and A5513.

Beneficiaries without Diabetes

Shoe inserts for beneficiaries with missing toes or partial foot amputations who are not diabetic are considered for coverage under the prosthetic benefit. Code L5000 is described by:

> L5000 - PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER

As noted in the descriptor, code L5000 describes a shoe insert with a rigid longitudinal arch support that also incorporates material accommodating the void left by the missing digit(s) or forefoot. Additional soft material is added where contact is made with the residual limb/toes. For beneficiaries missing digits, particularly the hallux (great toe), or the forefoot, L5000 inserts are designed to provide standing balance and toe off support for improved gait. The biomechanical control required of L5000 differs from the foot-protective function provided by inserts used as part of diabetes management.

For beneficiaries who are non-diabetic and require accommodation of missing foot digit(s) or forefoot, suppliers must only bill code L5000. Codes A5512 and A5513 describe inserts used with therapeutic shoes provided to persons with diabetes (see below) and must not be billed for non-diabetic beneficiaries.

Beneficiaries with Diabetes

A separate benefit category allows Medicare coverage of therapeutic shoes and inserts for persons with diabetes. Shoe inserts for persons with diabetes are described by the codes below:

> A5512 - FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH
>
> A5513 - FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH

For a beneficiary with diabetes missing digit(s) or a forefoot, suppliers have two options for billing inserts:

Option 1: For diabetic beneficiaries who do not require the rigidity and support afforded by code L5000 (e.g., beneficiaries missing digits excluding the hallux), suppliers must bill code A5513 for an insert appropriately custom-fabricated to accommodate the missing digit(s). Codes L5000 or A5512 may not be billed in addition to code A5513.

Option 2: For beneficiaries missing the hallux or a forefoot that require rigidity and support for effective gait, suppliers must bill L5000 for an insert appropriately custom-fabricated to accommodate the missing digit(s) or forefoot as well as providing the foot-protective functions required for a person with diabetes. Codes A5512 or A5513 may not be billed in addition to code L5000.

Suppliers are encouraged to review both the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination and related Policy Article and the Lower Limb Prostheses Local Coverage Determination and related Policy Article for additional information on the coverage, coding and documentation of these items.

Widespread Prepayment Probe for Pressure Reducing Support Surfaces Group 2 - HCPCS Code E0277 (POWERED PRESSURE-REDUCING AIR MATTRESS) (MOB)

DME MAC A will be initiating a widespread complex prepayment probe review of claims submitted with HCPCS Code E0277 (POWERED PRESSURE-REDUCING AIR MATTRESS). This review is being initiated due to a high volume of claim errors identified by the Comprehensive Error Rate Testing (CERT) contractor.

Suppliers will be sent a documentation request for information listed below. The requested documentation must be returned within 45 days from the date of the letter to avoid claim denials.

Documentation should include the following per the Local Coverage Determination (LCD) for Pressure Reducing Support Surfaces - Group 2 (L5068):

1. Detailed written order prior to delivery.

2. Information from the medical record that demonstrates the reasonable and necessary coverage criteria for the item(s) are met. Include detailed information about the following:

   Group 2 support surfaces are covered if:

   Criteria 1 - The patient has multiple stage II pressure ulcers located on the trunk or pelvis (ICD-9 707.02 -707.05), **AND**

Criteria 2 - Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface, **AND**

Criteria 3- The ulcers have worsened or remained the same over the past month.

OR

Criteria 4 - The patient has large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis (ICD-9 707.02 -707.05)

OR

Criteria 5 - The patient had a recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) (ICD-9 707.02 - 707.05) (coverage generally is limited to 60 days from the date of surgery), **AND**

Criteria 6 - The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

3. Proof of delivery with beneficiary's name, address and signature of the beneficiary (or designee), sufficiently detailed description to identify the item(s) delivered (e.g., brand name, serial number, narrative description); quantity and date of delivery

4. Invoice(s) for the item(s) provided including manufacturer name and model number.

5. Any other pertinent information that would justify payment for the item(s) provided.

6. Advanced Beneficiary Notice of Noncoverage(ABN) if one was obtained, this must be submitted with the above requested documentation.

To avoid unnecessary denials for missing or incomplete information, please ensure when submitting documentation requests that all requested information is included with your file and respond in a timely manner.

It is important for suppliers to be familiar with the coverage criteria and documentation requirements as outlined in the LCD and related Policy Article. Suppliers can review the LCD for Pressure Reducing Support Surfaces - Group 2 (L5068) at: **http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml**

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

Contacting Provider Outreach & Education (GEN)

The Provider Outreach & Education Team direct phone number has been discontinued in support of the Customer Service Triage approach. Suppliers must contact Customer Service at (866-590-6731) with any questions or issues. Supplier inquiries will be addressed via the following triage approach and forwarded to Provider Outreach & Education as necessary.

The Triage/Tier approach to Customer Service is as follows:

- Tier 1 Representatives
  - Basic questions
  - Eligibility (*must be confirmed through the IVR before speaking to a representative*)
  - Claim Status (*must be confirmed through the IVR before speaking to a representative*)
  - Authority to refer to Level 2
- Tier 2 Representatives
  - More complex inquiries
  - More experience and training
  - Policies, Medical Review
- PRRS (Provider Relations Research Specialists)
  - Most complex inquiries to research
  - Have a 45 day turn around to allow additional research time
  - Issues that cannot be handled by Tier I or Tier 2
  - Will refer issues to the Outreach & Education Team as appropriate

Suppliers cannot go directly to a Level 2 CSR; they must go through this established structure.

All inquiries need to be routed through the Triage. The PRRS handles complex supplier issues that cannot be addressed by a Tier I or Tier 2 Representative. If the PRRS believes something needs to be addressed by the O&E Team, they will then refer the issue to the Outreach & Education Team as appropriate for global education.

Important Reminder - Using the correct address for the Overpayment Refund Form (GEN)

Please be sure to use the correct forms when submitting a request to NHIC, Corp. DME MAC A.

It has come to our attention that incorrect *Overpayment Refund Forms* are being submitted to the incorrect address for DMEPOS Supplier requests.

The correct form and addresses/fax numbers are:

Overpayment Refund Form **http://www.medicarenhic.com/dme/forms/overpayment_refund_form.pdf**		
Voluntary Refund **Check Attached** NHIC, Corp. Medicare Overpayments P.O. Box 809252 Chicago, IL 60680-9252	Voluntary Refund **Check Not Attached** Medicare Overpayments P.O. Box 9175 Hingham, MA 02043-9175	Voluntary Refund **Check Not Attached** Fax: 781-383-4513

Submitting correct forms will ensure that requests are processed correctly and efficiently, and avoid the additional workload of having to resubmit your request.

Avoid Claim Denials for Ordered/Referred Services (GEN)

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

If you order or refer items or services for Medicare beneficiaries, or bill for these services, please read these CMS resources to be sure you are following Medicare requirements.

MLN Matters Articles

- SE1221 *Phase 2 of Ordering and Referring Requirement*
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1221.pdf

- SE1011 *Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims*
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf

MLN Fact Sheets

- "*Medicare Enrollment Guidelines for Ordering/Referring Providers*"
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf

- "*The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement*"
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_Phys_Infreq_Reimb_FactSheet_ICN006881.pdf

All providers may also confirm whether or not an eligible ordering or referring provider is enrolled in Medicare by reviewing the Ordering and Referring File (**http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html**) on the CMS website.

KX Modifier Billing Reminder (GEN)

Supplier usage of the KX modifier identifies that the requirements identified in the medical policy have been met. Documentation is essential to support that the item is reasonable and necessary and that the specific coverage criteria specified in each policy have been met.

The KX modifier has differing requirements for usage depending on the specific Local Coverage Determination (LCD); suppliers should review the LCDs carefully to understand the documentation requirements and the proper use of the KX modifier for each policy.

Review any applicable LCDs that include the KX modifier requirement at:
www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

Below is a list of LCDs which include a KX modifier requirement for some or all items within that specific LCD. Use of the KX modifier with any other DMEPOS is inappropriate usage.

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- Automatic External Defibrillators
- Cervical Traction Devices
- Commodes
- External Infusion Pumps
- Glucose Monitors
- High Frequency Chest Wall Oscillation Devices
- Hospital Beds
- Immunosuppressive Drugs
- Knee Orthoses
- Manual Wheelchair Bases
- Nebulizers
- Negative Pressure Wound Therapy Devices
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- Oral Appliances for Obstructive Sleep Apnea
- Orthopedic Footwear
- Patient Lifts
- Positive Airway Pressure Devices
- Power Mobility Devices
- Pressure Reducing Support Surfaces
- Refractive Lenses
- Respiratory Assist Devices
- Speech Generating Devices
- Therapeutic Shoes for Persons with Diabetes
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Urological Supplies
- Walkers
- Wheelchair Options and Accessories
- Wheelchair Seating

It is important to remember, if the requirements specified in the LCD are not met the KX modifier must not be used.

Most LCDs include a modifier which indicates the documentation requirements are not met by appending either a GA, GY, or GZ modifier if a claim is denied for missing one of these modifiers it must be resubmitted. Refer to the *KX, GA, GZ and GY Modifiers - New Uses* (**http://www.medicarenhic.com/dme/articles/072209_kx.pdf**) article for additional information.

Be sure to review each LCD closely to determine which modifier is appropriate when the LCD documentation requirements are not met.

Second Quarter 2012 - Top Claim Submission Errors (GEN)

A Claim Submission Error (CSE) is an error made on a claim that would cause the claim to reject upon submission to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The top ten American National Standards Institute (ANSI) Claim Submission Errors for April through June 2012 are provided in the following table.

Note: *The data provided below is a combination of results from all four DME MACs, causing the number of errors to be significantly higher. The edits listed are in version 5010A1.*

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-2.020 - Rejected for relational field Information within the HCPCS	148,919	The procedure code, modifier, or procedure code and modifier combination is invalid.
X222.121.2010BA.NM109.020 - Invalid Information for a Subscriber's contract/member number	35,955	The patient's Medicare ID (HICN) is invalid. Verify the number on the patient's red, white, and blue Medicare card.
X222.094.2010AA.REF02.050 - Relational field Billing Provider NPI and Tax ID	24,645	Billing Provider Tax Identification Number must be associated with the billing provider's NPI. Verify that the information you are submitting matches the information on file with the NPPES and NSC.
X222.087.2010AA.NM109.050 - Billing Provider's submitter not approved for electronic claim submissions on behalf of this Billing Provider	24,637	The NPI submitted is not linked to the Submitter ID under which the claim file was sent. If this error is received, the supplier must complete and sign the appropriate form on the CEDI Web site and return to CEDI for processing.

Top Ten Claims Submission Errors	Number Received	Reason For Error
X222.351.2400.SV101-7.020 - Missing Information within the Detailed description of service	23,567	The narrative information is missing. The procedure code submitted requires narrative information.
X222.226.2300.HI01-2.030 - Invalid Information within the Primary diagnosis code	23,056	The diagnosis code pointed to as the first relevant diagnosis on the claim was not valid for the date of service.
X222.087.2010AA.NM109.030 - Invalid information in the Billing Provider's NPI	22,362	Billing Provider Identifier must be a valid NPI on the Crosswalk. Verify that the NPI and PTAN are linked together. To establish a crosswalk, verify the supplier's information listed on the NPPES web site matches the information at the NSC.
X222.380.2400.DTP03.090 - Invalid Information within the Date(s) of service	19,545	The procedure code submitted for this line does not allow for spanned dates of service. Verify the from and to dates for this line are equal.
X222.380.2400.DTP03.080 - Invalid Information within the Future date and Date(s) of service	15,943	The service start/from date is greater than the date this claim was received.
X222.351.2400.SV101-3.020 - Missing Information within the Procedure Code Modifier(s) for Service(s) Rendered	14,639	Procedure Modifier must be valid for the Service Date.

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

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

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

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form(or electronic equivalent) Entry Requirement	Number Received
CO 4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.	31,432
CO 182 N56 Procedure modifier was invalid on the date of service.	**Item 24d** - An invalid modifier (KH, KI, KJ) was submitted for the date of service billed.	11,071
CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different.	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.	3,086
CO 16 MA130 Claim/service lacks information which is needed for adjudication. Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	**Item 11** - If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE." (Paper Claims Only).	2,308
CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid information on where the services were furnished.	**Item 32** - Enter the name, address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.	1,961

Claims Submission Errors (Return/Reject Denials)	CMS 1500 Form(or electronic equivalent) Entry Requirement	Number Received
CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or rates.	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable show HCPCS modifiers with the HCPCS code.	1,887
CO 16 N257 Missing / incomplete / invalid billing provider/supplier primary identifier.	**Item 33** - Provider Transaction Access Number (PTAN) number submitted in error. Must submit National Provider Identifier (NPI).	728
CO 16 M51, N225, N29 Claim/service lacks information which is needed for adjudication. Missing / incomplete / invalid procedure code(s) and/or dates. Missing incomplete / invalid documentation.	**Item 24D** - Enter the procedures, services or supplies using the Healthcare Common Procedure Coding System (HCPCS). NOC (Not Otherwise Classified) codes billed and a narrative description was not entered.	636
CO 16 N265, N286 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid ordering provider primary identifier.	**Item 17B** - Enter the NPI of the referring or ordering physician, if the service or item was ordered or referred by a physician.	631
CO 16 M76, M81 You are required to code to the highest level of specificity. Missing / incomplete / invalid diagnosis or condition.	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity.	588

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

Supplier Manual News (GEN)

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

Updates/Corrections Made:

In June of 2012 chapters 2, 3, 11, and 12 of the *DME MAC A Supplier Manual* were updated. In July 2012 chapter 10 was 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.

Quarterly Provider Update (GEN)

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

Updating Supplier Records (GEN)

If you have moved, or are planning to move, and have not yet sent in a "Change of Information" form (CMS-855S), be sure to notify the National Supplier Clearinghouse (NSC) of your new address immediately. Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information must be reported in writing to the NSC within 30 days after such changes have taken place.

If you wait, your payments can be suspended. When an item is sent to a supplier's "Pay To" address and is returned by the U.S. Postal Service noting "Do Not Forward" (DNF), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A) places a DNF code on the supplier's file. The DNF code suspends payments for that supplier number. The supplier must then verify their address with the NSC in writing.

Note: *A request to change your address should not be sent to DME MAC A since we cannot change supplier files.*

For instructions on the completion and mailing of CMS-855S, visit the CMS Forms web site at **http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html** to download the Form.

Failure to provide the updated information is grounds for denial or revocation of a Medicare billing number.

DME MAC 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**

DME MAC Jurisdiction A Web Site Customer Satisfaction Survey (GEN)

NHIC, Corp. DME MAC Jurisdiction A is committed to ensuring that our Web site meets the needs of our users. We continually strive to improve our offerings based on the information and feedback we receive from you. In order to accomplish this, we offer *The DME MAC A Web site Customer Satisfaction Survey*. This survey is designed to collect information that helps measure providers' satisfaction with contractors' Web sites with a focus on customer service.

If you see the **Customer Satisfaction Survey** pop up while you are browsing the DME MAC A Web site, please take a moment to participate. Completion should only take a few minutes.

As our site is constantly changing, we would appreciate your input! We are listening... It is **your** feedback that makes those changes possible!

Thank you for taking the time to provide us with your comments! Remember, it is your feedback that makes changes possible in order to address your Medicare needs!

If you see the **Customer Satisfaction Survey** pop up while you are browsing the DME MAC A Web site, please take a moment to participate. Completion should only take a few minutes.

For Your Notes

Join the NHIC, Corp. DME MAC A ListServe!

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

Helpful Contacts

Customer Service Telephone

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

Outreach & Education

Outreach-education@hp.com

Claims Submissions

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

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

Written Inquiries

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

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

Overpayments

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

Payment Offset Fax Requests: 781-741-3916

Note: I*nclude both the demand letter or the remittance indicating the overpayment, and the Offset Request Form*

Appeals and Reopenings

Telephone Reopenings: 317-595-4371

Redetermination Requests Fax: 781-741-3118

Redeterminations:
DME - Redeterminations
P.O. Box 9150
Hingham, MA 02043-9150

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

Faxed Reopenings: 781-741-3914

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

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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

The Jurisdiction A DME MAC will continue to offer our quarterly bulletin, the *DME MAC Jurisdiction A Resource*, in electronic format via our Web site, where copies can be printed free of charge. To access the bulletin, go to the "Publications" section of our Web site at: **http://www.medicarenhic.com/dme/dme_publications.shtml**. To be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, subscribe to the DME MAC A ListServe, our electronic mailing lists by visiting: **http://www.medicarenhic.com/dme/listserve.html**

For Suppliers without Internet Access: If you do not have Internet access and require the bulletin via hardcopy or CD-ROM*, you may subscribe to it for a fee. The annual subscription fee is $65.00 for hardcopy and $172.00 for CD-ROM. *This subscription includes the four quarterly bulletins published during the calendar year of 2013 - March, June, September and December.* Complete this form and submit with payment, via check only, to the address listed below.

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Mail your completed form with payment to: **NHIC, Corp.**
Cash Accounting / DME Subscription
75 Sgt William B Terry Drive
Hingham, MA 02043

Signature: _____ Date: _____