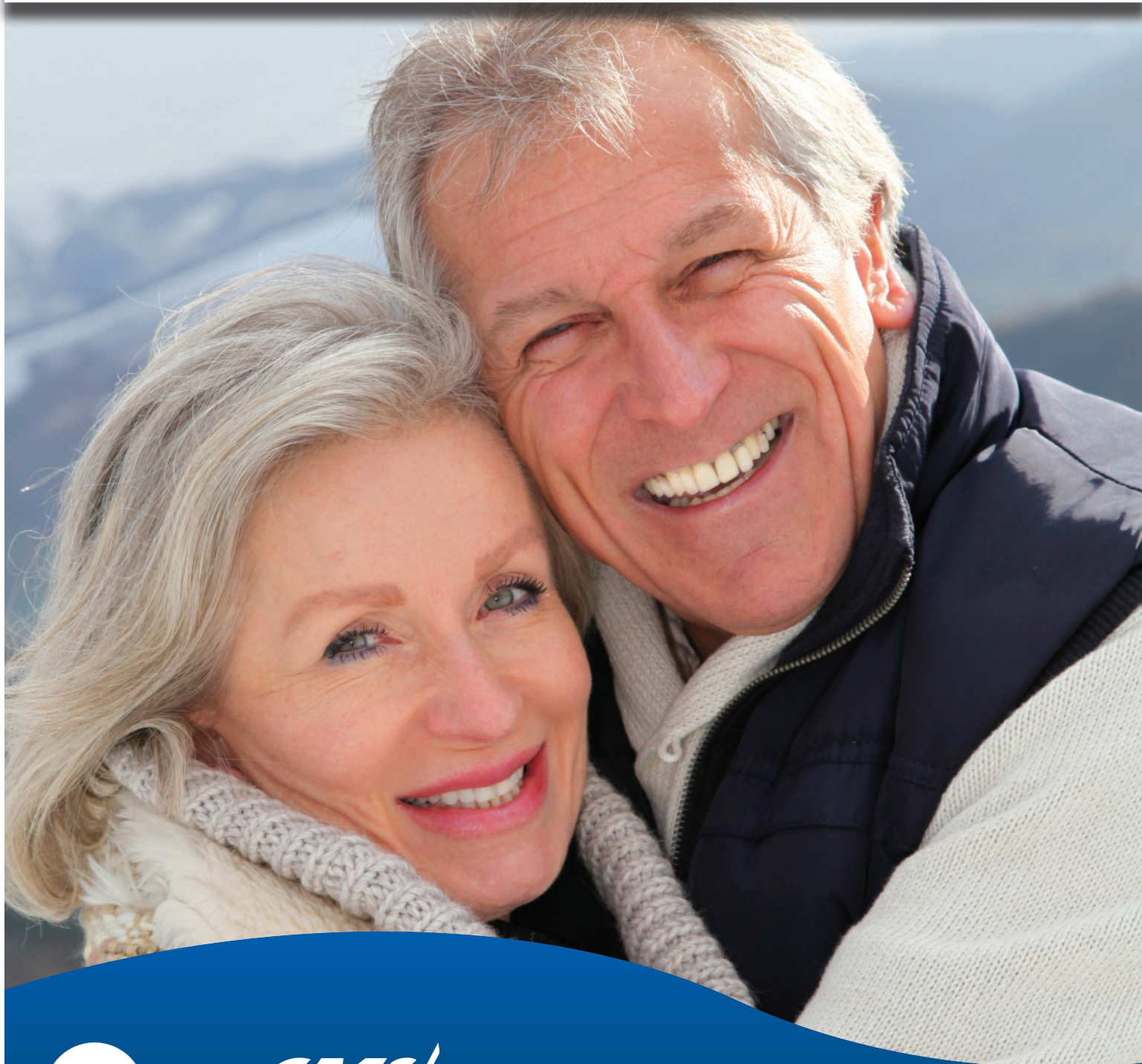


The DME MAC Jurisdiction C

INSIDER



Edition 22 • Winter 2013

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Notice: CGS Administrators, LLC, Jurisdiction C Durable Medical Equipment Medicare Administrative Contractor (DME MAC), will provide a quarterly publication to all suppliers in the coverage area (Jurisdiction C includes: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia). The DME MAC Jurisdiction C Insider will contain important information that will assist the supplier community in day to day operations. It will include information published during the previous quarter by the Centers of Medicare and Medicaid Services (CMS) and by CGS.

News From the Inside

News from the Inside

This issue of the Insider features the debut of a new section—*News from the Inside*. In this section you will find articles written by experienced members of the CGS Jurisdiction C staff regarding the latest news topics, billing suggestions, and other general tips to help you efficiently and accurately file DMEPOS claims, appeals, and other requests. We hope that you will find this section to be a helpful tool as you navigate the world of Medicare.

Introducing myCGS

The Jurisdiction C Web Portal

Coming in Early 2013!

CGS DME MAC Jurisdiction C is pleased to introduce **myCGS**, a web-based application developed specifically to serve the needs of DMEPOS suppliers in Jurisdiction C. Beginning in early 2013, you will be able to use myCGS to access a variety of Medicare claim-based information, including beneficiary eligibility, claim status, claim denial information, and much more. We believe that you will find myCGS to be a fast and user-friendly application that will help you save time and money.

The myCGS portal mirrors all of the functionality currently contained in the Jurisdiction C Interactive Voice Response (IVR) unit, along with several additional and more detailed features than what the IVR can provide. The main abilities of myCGS are divided into a series of functions—Beneficiary Eligibility, Claims, CMNs, Finance, and Redeterminations. Once myCGS is released, you will be able to navigate seamlessly between these functions to find the type of information you need. Below is a preview of what each of these functions will provide.

Beneficiary Eligibility

The *Beneficiary Eligibility* function will give you access to a variety of eligibility information about Medicare beneficiaries, such as effective dates, deductible, primary insurance, inpatient stays, Medicare Advantage Plans, and more.

Claims

The *Claims* function will offer status for claims you have submitted to Jurisdiction C, including detailed information about claim denials. The claim denial explanations found in myCGS are one of the things that make our web portal unique. Instead of the simple and generic claim explanations found on your remittance advice, myCGS will give you detailed explanations of why your claim denied and what steps you can take if you disagree with the denial. It's almost like having your own personal Customer Service Representative!

Claim Preparation

The *Claim Preparation* function will give you access to a variety of information to assist you in filing a complete and accurate claim. Within this tab you will find information about a beneficiary's Certificates of Medical Necessity (CMNs) that are on file, ordering/referring physician status, and claim history for diabetic testing supplies and diabetic shoes.

Finance

The *Finance* function will give you access to information regarding checks, offsets, pricing, and electronic funds transfer (EFT).

Redeterminations

The Redeterminations function will provide current status of a redetermination request.

For the latest news and updates regarding myCGS, including the product release date, be sure to monitor the News (<http://www.cgsmedicare.com/jc/pubs/news/index.html>) age on our website. To make sure you don't miss important DME MAC news, subscribe to our ListServ (http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp), the CGS electronic mailing list. To join the ListServ, visit our website at http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp.

PWK Tips & Reminders

On October 1, 2012, the DME MACs began accepting the PWK (paperwork) segment on electronic claims. When using the PWK segment, be sure to complete the CGS PWK Fax/Mail Coversheet (<http://www.cgsmedicare.com/jc/forms/pdf/PWKcoversheet.pdf>) {found on the Forms page (<http://www.cgsmedicare.com/jc/forms/index.html>) of the Jurisdiction C website} in its entirety and to complete the PWK segment on your electronic claim. Below are a few tips and reminders regarding PWK submissions based on the most common errors that we have seen since PWK was implemented.

- Complete the PWK coversheet in its entirety, including the Claim Control Number (CCN) of your claim.
- When mailing or faxing a PWK coversheet and documentation, be sure that you have completed the PWK indicator on the claim.
- The PWK coversheet and documentation must be submitted within seven calendar days if faxed or ten calendar days if mailed. You cannot use the PWK coversheet to request an adjustment to a completed claim.
- You cannot use PWK to respond to an additional documentation letter. If you receive a request letter from a ZPIC, RAC, DME MAC, or other contractor, follow the instructions on the letter when sending your response.
- Complete a PWK coversheet for each claim in which you are sending paper documentation. Do not combine CCNs onto the same coversheet.

For additional information about PWK, refer to the *DME MAC Jurisdiction C Supplier Manual* (<http://www.cgsmedicare.com/jc/pubs/supman/index.html>), Chapter 6.

Tips for Sending Faxes to CGS

CGS accepts faxed documentation in a number of different situations, such as when you are sending a request for a reopening, a request for a redetermination, or a response to a request for additional claim information. In order to ensure that your faxed request is processed accurately and quickly, we encourage you to follow a few basic faxing tips.

- Send each individual request as a separate fax submission. Do not combine requests or responses into a single fax.
- If you represent multiple business or locations, ALWAYS separate fax requests from each business/location.
- Make sure the document you are faxing is clear and legible.
- Send each request/response only one time. Sending duplicate responses may increase the processing time of your request/response.
- Include all documents needed for your request/response at one time. Do not break a single request/response into multiple faxes.
- If you are faxing a PWK document (<http://www.cgsmedicare.com/jc/pubs/news/2012/0312/COPE18270.html>), be sure to use the PWK Fax/Mail Coversheet (<http://www.cgsmedicare.com/jc/forms/pdf/PWK Coversheet.pdf>).
- Only use the PWK Coversheet (<http://www.cgsmedicare.com/jc/forms/>) in conjunction with use of the PWK (<http://www.cgsmedicare.com/jc/pubs/news/2012/0312/COPE18270.html>) segment on a claim, not for other types of requests/responses.
- If you are faxing a response to a documentation request letter, place a copy of the documentation request letter you received **before** the documents you are including in your response.
- When sending a request, be sure to use the correct form/coversheet. Refer to the Forms page (<http://www.cgsmedicare.com/jc/forms/index.html>) on our website.
- Be sure to use the correct fax number for the type of response/request you are sending. Fax numbers can be found on the appropriate form/coversheet for the type of request you are sending. If you are responding to a documentation request letter, refer to the letter for the correct fax number. Fax numbers can also be found on our Contacts page (<http://www.cgsmedicare.com/jc/help/contact/contactinfo.html>) and in the *DME MAC Jurisdiction C Supplier Manual*, Chapter 15 (<http://www.cgsmedicare.com/jc/pubs/pdf/Chpt15.pdf>).

You can find additional information and resources about faxing requests to CGS, as well as a wide range of other important Medicare topics, in the *DME MAC Jurisdiction C Supplier Manual* (<http://www.cgsmedicare.com/jc/pubs/supman/index.html>). If you need additional assistance, please contact our Customer Service department at 1.866.270.4909.

Coverage & Billing

Refill Requirements for Non-Consumable Supplies – Frequently Asked Questions

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 08/02/2011 – 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

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)
- Urologic Supplies

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

This 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*.

Changing a 7-Element-Order for a Power Mobility Device

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

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

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

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

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

For more information, please refer to the Power Mobility Devices LCD by clicking on the following link. <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>

Numerical Rounding Rules for Medicare

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

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

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

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

Consumable Supplies - Request for Refill Documentation Requirements

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

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

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

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

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

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

Centers for Medicare & Medicaid Services Approved Clinical Trials

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

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

1. Transcutaneous Electrical Nerve Stimulation (NCD Manual, Chapter 1, Section 160.27);
2. Home Use of Oxygen in Approved Clinical Trials (NCD Manual, Chapter 4, Section 240.2.1)

3. Home Oxygen Use to Treat Cluster Headaches (NCD Manual, Chapter 4, Section 240.2.2)

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

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

Surgical Dressings – Benefit Category Reminder

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

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

Primary dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. Items

such as adhesive tape, roll gauze, bandages, and disposable compression material are examples of secondary dressings. Elastic stockings, support hose, foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are examples of items that are not ordinarily covered as surgical dressings. Some items, such as transparent film, may be used as a primary or secondary dressing.

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

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

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

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

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

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

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

and reimbursement of gradient compression stockings to the following situation:

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

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

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

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

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

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

Suppliers should refer to the Surgical Dressings LCD and related Policy Article for additional coverage, coding and documentation requirements at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Coverage Reminder - Testing for Oxygen and Oxygen Equipment Coverage

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

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

- Arterial Blood Gas (ABG) testing – direct testing of oxygen content from an arterial blood sample
- Oximetry – also known as "spot" or "pulse" oximetry involves the determination of percent (%) oxygen saturation via a transcutaneous sensor. There are three types of oximetry testing used for qualification for payment:

- At rest oximetry
- Overnight oximetry
- Exercise oximetry

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

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

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

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

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

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

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

Refer to the Oxygen and Oxygen Equipment LCD and related Policy Article at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>, for additional information.

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

MLN Matters® Number: MM7355 **Revised**

Related Change Request (CR) #: 7355

Related CR Release Date: August 3, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R87MSP

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

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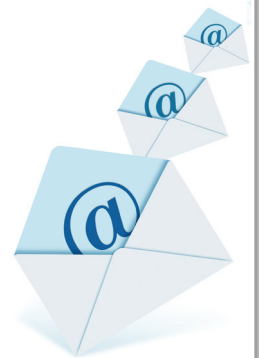
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Medicare contractors will no longer be accepting 4010 claims; Providers must submit claims in the 5010 format beginning on this date.

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)	Condition Code (2300 HI)	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/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).

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Handling Form CMS-1500 Claims Where an ICD-9-CM “E” Code is Reported as the First Diagnosis on the Claim

MLN Matters® Number: MM7700

Related Change Request (CR) #: 7700

Related CR Release Date: August 8, 2012

Effective Date: Claims received with an “E” code on or after January 1, 2013

Related CR Transmittal #: R2515CP

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.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM7905

Related Change Request (CR) #: CR 7905

Related CR Release Date: August 2, 2012

Effective Date: October 1, 2012

Related CR Transmittal #: R2508CP

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.

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

MLN Matters® Number: MM8007

Related Change Request (CR) #: CR 8007

Related CR Release Date: November 1, 2012

Effective Date: April 1, 2013

Related CR Transmittal #: R1134OTN

Implementation Date: April 1, 2013

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8007, which informs Medicare contractors about the creation of a new Informational Unsolicited Response (IUR) process to identify and perform

retroactive adjustments on any previously paid claims which may have been processed and paid erroneously during periods when the beneficiary data in the Enrollment Database (EDB) did not reflect the fact that the beneficiary was incarcerated.

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

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

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

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

Background

Under Sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Accordingly, the Centers for Medicare & Medicaid Services (CMS) presumes that a State or local government entity that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of medical services and Medicare will generally not reimburse claims for services rendered to a beneficiary while he/she is in such custody.

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

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

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

CMS Transmittal AB-02-164, CR2022, issued on November 8, 2002, implemented a Medicare systems edit to reject services

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billed to Medicare when information in the EDB indicates that, on the date of service, the beneficiary was incarcerated. Upon receipt of this rejection, Medicare contractors are instructed to deny the claims. CR4352, which manualized CR2022, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R883CP.pdf> on the CMS website.

OIG Finding of Vulnerability

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

Creation of IUR to Remedy Vulnerability

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

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

Additional Information

The official instruction, CR8007, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1134OTN.pdf> on the CMS website.

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

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

MLN Matters® Number: MM8009

Related Change Request (CR) #: CR 8009

Related CR Release Date: November 1, 2012

Effective Date: April 1, 2013

Related CR Transmittal #: R1133OTN

Implementation Date: April 1, 2013

Provider Types Affected

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

What you Need to Know

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

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

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

Background

Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) prohibited aliens who are not "qualified aliens" from receiving Federal benefits, including

Medicare benefits. Consistent with this legislation, Section 10.1.4.8 of Chapter 1 of the “Medicare Claims Processing Manual” (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>) states that: “Medicare payment may not be made for items and services furnished to an alien beneficiary who was not lawfully present in the United States on the date of service.”

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

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

OIG Finding of Vulnerability

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

Creation of IUR to Remedy Vulnerability

CMS has identified a process to mitigate this vulnerability. An IUR identifies a claim that appears to need to be adjusted by a Medicare contractor. The contractor, when appropriate, initiates overpayment recovery procedures to retract Part A or Part B payment. Therefore, the intent of CR 8009 is to create a new process to identify and perform retroactive adjustments on any previously paid claims which may have been paid erroneously during periods when the beneficiary data in Medicare’s files did not reflect the fact that the beneficiary was unlawfully present in the United States.

Additional Information

You can find the official instruction, CR8009, issued to your Medicare Carrier, FI, DME MAC, RHHI, or A/B MAC by visiting <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1133OTN.pdf> on the CMS website.

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

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM8045

Related Change Request (CR) #: CR 8045

Related CR Release Date: September 14, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2547CP

Implementation Date: January 7, 2013

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

Additional Information

The official instruction, CR8045, issued to your Medicare contractor regarding this change, may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2547CP.pdf> on the CMS website.

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

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

MLN Matters® Number: MM8100

Related Change Request (CR) #: CR 8100

Related CR Release Date: October 26, 2012

Effective Date: January 28, 2013

Related CR Transmittal #: R160BP

Implementation Date: January 28, 2013

Provider Types Affected

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

Provider Action Needed

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

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

Background

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

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

Additional Information

The official instruction, CR 8100, issued to your carrier or A/B MAC regarding this change may be viewed at <http://www.cms.gov>.

hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R160BP.pdf on the CMS website. The revised manual sections are attached to CR8100.

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

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

MLN Matters® Number: SE1011 *Revised*

Related Change Request (CR) #: 6421, 6417, 6696, 6856

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R7810TN

Implementation Date: N/A

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

Provider Types Affected

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

Provider Action Needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare.. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-8550). Review the background and additional information below and make sure that your billing staffs are aware of these updates.

What Providers Need to Know

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

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

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

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

Background

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

Below are examples of some of these types of claims:

- Claims from laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures; and
- Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS.

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
- Physician Assistant,
- Clinical Nurse Specialist,
- Nurse Practitioner,
- Clinical Psychologist,

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

Questions and Answers Relating to the Edits**1. What will the edits do?**

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

2. Why did Medicare implement these edits?

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

3. How and when will these edits be implemented?

These edits are being implemented in two phases:

- **Phase 1:** Beginning October 5, 2009, if the billed Part B service requires an ordering/referring provider and the ordering/referring provider is not reported on the claim, the claim is not paid. If the ordering/referring provider is reported on the claim, but does not have a current Medicare enrollment record or is not of a specialty that is eligible to order and refer, the claim was paid, but the billing provider received an informational message¹ in the Medicare Remittance Advice² 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
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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
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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:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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 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

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

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

On January 28, 2010, CMS made available to the public, via the Downloads section of the “Ordering Referring Report” page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report on a 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. The final rule uses technically correct terms: 1) a provider "orders" non physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.
2. **Orders or referrals by interns or residents.** The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.
3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense(DoD)/Tricare.** These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
4. **Orders or referrals by dentists.** Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out

the paper CMS-8550 or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review MLN Matters® Article SE1201 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf>) and SE1221 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1221.pdf>) for important reminders on the requirements for Ordering and Referring Physicians.

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

Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs)

MLN Matters® Number: SE1128 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

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)	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Entitled 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.

Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers

MLN Matters® Number: SE1201 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

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

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

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

CAUTION – What You Need to Know

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

GO – What You Need to Do

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

Background

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring

provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

CMS would like to highlight the following limitations:

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

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

Additional Information

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

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

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

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

[MLNMattersArticles/Downloads/MM6417.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf) on the CMS website.

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

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

Phase 2 of Ordering/Referring Requirement

MLN Matters® Number: SE1221

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Note: This article was revised on November 1, 2012, to replace a reference to the Social Security Act on page 2 with a reference to the Affordable Care Act. Also, on page 3, a clarification is made regarding the type of providers who may order/refer Portable X-Ray services. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

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

Provider Action Needed

STOP – 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-8550).

Background

The Affordable Care Act requires physicians or other eligible professionals to be enrolled in the Medicare Program to order/ refer items or services for Medicare beneficiaries. Also, 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 these requirements for ordering and referring providers as follows:

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

Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:

- Physician (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry),
- Physician Assistant,
- Clinical Nurse Specialist,
- Nurse Practitioner,
- Clinical Psychologist,
- Interns, Residents, and Fellows
- Certified Nurse Midwife, and
- Clinical Social Worker.

The following exception is applicable for Part B services:

- Only Doctors of Medicine or Osteopathy may order/refer Portable X-Ray services.

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.
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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 identifiers.
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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:	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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 RHHs 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_OrderReferProvFactSheet_ICN906223.pdf on the CMS website.

[MLN/MLNProducts/downloads/MedEnroll_OrderReferProvFactSheet_ICN906223.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProvFactSheet_ICN906223.pdf) on the CMS website.

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

- MLN Matters® Article MM6417, "Expansion of the Current Scope of Editing for Ordering /Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6417.pdf> on the CMS website.
- MLN Matters® Article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6421.pdf> on the CMS website.
- MLN Matters® Article MM6856, "Expansion of the Current Scope of Editing for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) claims processed by Medicare Regional Home Health Intermediaries (RHHIs)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf> on the CMS website.
- MLN Matters® Article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7097.pdf> on the CMS website.
- MLN Matters® Article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6129.pdf> on the CMS website.
- MLN Matters® Special Edition Article SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B Claims (Change Requests 6417, 6421, and 6696)," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf> on the CMS website.
- MLN Matters® Article Special Edition Article SE1201 "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1201.pdf> on the CMS website.
- MLN Matters® Special Edition Article SE1208, "855-O Medicare Enrollment Application Ordering and Referring Physicians or Other Eligible Professionals," is available at

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1208.pdf> on the CMS website.

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

Clarification of the Quality Standards and Accreditation Requirements for Ultra Lightweight Manual Wheelchairs

MLN Matters® Number: SE1233

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: March 1, 2013

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

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

Provider Action Needed

STOP - Impact to You

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

CAUTION - What You Need to Know

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

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

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

the K0005 wheelchair. See Background section of this article for further information about Appendix B.

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

GO – What You Need to Do

Make sure that your staffs are aware of these requirements.

Background

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

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

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

I. Manual Wheelchairs

A. Intake & Assessment

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

B. Delivery & Set-up

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

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

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

D. Follow-up

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

II. Power Mobility Devices

A. Intake & Assessment

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

positioning and specialty assistive technology have been evaluated and documented in the beneficiary's record.

B. Delivery & Set-up

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

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

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

D. Follow-up

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

III. Complex Rehabilitative Wheelchairs and Assistive Technology

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

1. Employ (W-2 employee) at least one qualified individual as a Rehabilitative Technology Supplier (RTS) per location. A qualified RTS is an individual that has one of the following credentials:

- ✓ Certified Rehabilitative Technology Supplier (CRTS);
- ✓ Assistive Technology Supplier (ATS) (discontinued 12/31/2008);
- ✓ Assistive Technology Practitioner (ATP) (discontinued 12/31/2008);
- ✓ Assistive Technology Professional (ATP) (effective 1/1/2009).

2. The RTS shall have at least one or more trained technicians available to service each location appropriately depending on the size and scope of its business. A trained technician is identified by the following:

- ✓ Factory trained by manufacturers of the products supplied by the company;
- ✓ Experienced in the field of Rehabilitative Technology, (e.g., on the job training, familiarity with rehabilitative clients, products and services);
- ✓ Completed at least 10 hours annually of continuing education specific to Rehabilitative Technology; and
- ✓ Able to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems.

3. The RTS shall:

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

4. If beneficiaries are evaluated in the supplier's facility, the supplier shall:

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

A. Intake & Assessment

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

B. Delivery & Set-up

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

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

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

D. Follow-up

Refer to Section II: Supplier Product-Specific Service

Additional Information

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

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

MLN Matters® Number: SE1238

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

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

What You Need to Know

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

The objective of this OIG study was to determine whether the KX modifier was effective in ensuring that DMEPOS suppliers who submitted Medicare claims had the required supporting

documentation on file. The study included individual reviews of the four contractors that processed the DMEPOS claims for Jurisdictions A through D with dates of service in 2007.

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

1. Therapeutic shoes for diabetics,
2. Continuous positive airway pressure systems,
3. Respiratory assist devices, and
4. Pressure reducing support surfaces (groups 1 and 2).

Background

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

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

OIG Findings

The report found that in CY 2007:

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

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

Key Points

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

1. Therapeutic shoes for diabetics,
2. Continuous positive airway pressure systems,
3. Respiratory assist devices, and
4. Pressure reducing support surfaces (groups 1 and 2).

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

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

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

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

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

Therapeutic Shoes

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

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

2. Documentation of an in-person evaluation of the patient by the certifying physician who is managing the patient's systemic diabetes condition within 6 months specifying:
 - a. The patient has diabetes mellitus;
 - b. Has one of the conditions 2a-2f listed in Policy Article A37076 (<http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=37076&version=19&ContrId=139&LCDId=157&ContrVer=1&CoverageSection=Both&ArticleType=All&PolicyType=Final&s=All&K>

[eyWord=Therapeutic%2bShoes&KeyWordLookUp=Title&KeyWordSearchTy\);](#)

- c. Is being treated under a comprehensive plan of care for his/her diabetes, and
 - d. Requires diabetic shoes.
3. Documentation of an in-person evaluation of the patient by the supplier prior to selection of the items billed that included:
 - a. An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
 - b. For all shoes, taking measurements of the patient's feet.
 - c. For custom molded shoes and inserts, taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.
 4. Medical records supporting that the patient has diabetes mellitus and at least one of the conditions noted above.
 5. Documentation of an in-person visit with the patient by the supplier at the time of delivery must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

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

Continuous Positive Airway Pressure Systems

1. Documentation of a verbal order (if item is dispensed based on a verbal order) that contains:
 - a. Description of the item;
 - b. Name of the beneficiary;
 - c. Name of the physician, and
 - d. Start date of the order.
2. Valid written order that contains:
 - a. Beneficiary's name
 - b. Treating physician's signature
 - c. Date the treating physician signed the order
 - d. Start date of the order-if the start date differs from the signature date.
 - e. Order for PAP with pressure setting.
3. Beneficiary Authorization.
4. Proof of Delivery.
5. Face-to-Face clinical evaluation by the physician prior to the sleep test to assess the patient for obstructive sleep apnea (OSA) containing the following elements:
 - a. Sleep history and symptoms which may be caused by OSA;
 - b. Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea) or other validated sleep inventory, and
 - c. Pertinent physical examination – e.g., body mass index, neck circumference, upper airway exam, and cardiopulmonary exam.
6. Medicare-covered sleep test that meets either of the following criteria:
 - a. Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) greater than or equal to 15 events per hour with a minimum of 30 events; **OR**

- b. AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
 - i. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, **OR**
 - ii. Hypertension, ischemic heart disease, or history of stroke.
7. Documentation that the patient and/or caregiver received instruction from the supplier of the Positive Airway Pressure (PAP) device and accessories in the proper use and care of the equipment.
 8. To continue coverage for the PAP device (Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD)) beyond an initial 3-month trial period, there must be:
 - a. A face-to-face visit with the physician during the second or third month of the trial that documents an improvement of the beneficiary's symptoms; and
 - b. A data report from the PAP device which documents use of the PAP device for at least 4 hours per night on 70% of nights for a 30 consecutive day period during the trial.
 9. For beneficiaries who received a PAP device prior to Fee-For-Service (FFS) Medicare enrollment and are now enrolled in Medicare and are seeking a new PAP device and/or accessories, both of the following coverage requirements must be met:
 - a. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories, and,
 - b. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:
 - i. The beneficiary has a diagnosis of obstructive sleep apnea; and,
 - ii. The beneficiary continues to use the PAP device.

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

Respiratory Assist Devices

1. Documentation of a verbal order (if item is dispensed based on a verbal order) that contains:
 - a. Description of the item;
 - b. Name of the beneficiary;
 - c. Name of the physician, and
 - d. Start date of the order.
2. Valid written order that contains:
 - a. Beneficiary's name
 - b. Item to be dispensed
 - c. Pressure setting with or without backup rate
 - d. Treating physician's signature
 - e. Date the treating physician signed the order
 - f. Start date of the order if the start date differs from the signature date.
3. Beneficiary Authorization.
4. Proof of Delivery.

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

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

Pressure Reducing Support Surfaces (groups 1 and 2).

1. Valid written order that contains:
 - a. Beneficiary's name
 - b. Treating physician's signature
 - c. Date the treating physician signed the order
 - d. Start date of the order if the start date differs from the signature date.
 - e. Clear, detailed description of the type of support surface the physician is ordering.
2. Beneficiary Authorization.
3. Signed statement from the treating physician indicating what, if any, payment criteria the patient meets.
4. Medical records supporting patient meets the basic coverage criteria specified in the Pressure Reducing Support Surfaces-Group 1 and 2 LCD.

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

Additional Information

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

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

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

The DME MAC websites are available as follows:

- CGS (<http://www.cgsmedicare.com/jc/index.html>)
- National Government Services (http://www.ngsmedicare.com/wps/portal/ngsmedicare/home?CONTRACTTYPE=Jurisdiction%20B%20Suppliers&LOB=Durable%20Medical%20Equipment&utm_source=homepage&utm_medium=dme&utm_campaign=home)

[campaign=home](#))

- National Heritage Insurance Company (NHIC) (<http://www.medicarenhic.com/dme/index.asp>)
- Noridian Administrative Services (<https://www.noridianmedicare.com/dme/index.html%3f>)

Updated ICD-10 Implementation Information

MLN Matters® Number: SE1239

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

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

What You Need to Know

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

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

Thus, on **October 1, 2014**, medical coding in U.S. health care settings will change from ICD-9-CM to ICD-10. The transition will require business and systems changes throughout the health care industry.

Everyone who is covered by the Health Insurance Portability and Accountability Act (HIPAA) must make the transition, not just those who submit Medicare or Medicaid claims. The compliance dates are firm and not subject to change. If you are not ready, your claims will not be paid. Preparing now can help you avoid potential reimbursement issues.

Background

ICD-10 Implementation Compliance Date

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

- ICD-10-CM diagnosis codes will be used by all providers in every health care setting.

- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm and not subject to change.
 - There will be **no** delays.
 - There will be **no** grace period for implementation.

Important, please be aware:

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

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

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

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

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

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

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

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

What are Benefits of the ICD-10 Coding System?

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

- Measure the quality, safety, and efficacy of care
- Reduce the need for attachments to explain the patient's condition
- Design payment systems and process claims for reimbursement
- Conduct research, epidemiological studies, and clinical trials
- Set health policy
- Support operational and strategic planning
- Design health care delivery systems
- Monitor resource utilization

- Improve clinical, financial, and administrative performance
- Prevent and detect health care fraud and abuse
- Track public health and risks

ICD-10-CM Code Use and Structure

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

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

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

1. Laterality (left, right, bilateral)

For example:

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

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

For example:

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

3. Combination codes for poisonings and their associated external cause

For example:

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

4. Obstetric codes identify trimester instead of episode of care

For example:

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

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

For example:

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

6. Two types of Excludes notes

Excludes 1

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

For example:

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

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

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

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

For example:

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

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

For example:

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

9. Codes for postoperative complications have been expanded and a distinction made between intraoperative complications and postprocedural disorders

For example:

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

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

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

are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

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

ICD-10-PCS Code Use and Structure

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

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

Help with Converting Codes

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

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

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

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

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

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

the CMS website).

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

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

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

Additional Information

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

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

Note: Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

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

the **Medicare Fee-for-Service Provider Resources** link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

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

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

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

Partial Code Freeze Prior to ICD-10 Implementation

MLN Matters® Number: SE1240

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

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

What You Need to Know

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

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

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
- On October 1, 2012 and October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.
- On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173.

There will be no updates to ICD-9-CM, as it will no longer be used for reporting.

- On October 1, 2015, regular updates to ICD-10 will begin.

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

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

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

Additional Information

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

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

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

Note: Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

- **CMS Sponsored National Provider Conference Calls** - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing

education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit <http://www.cms.gov/Medicare/Coding/ICD10/index.html> on the CMS website.

- **See MLN Matters® Special Edition Article, SE1239**, at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf> for an overview of what is needed to implement ICD-10.
- **Frequently Asked Questions (FAQs)** - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>, select the **Medicare Fee-for-Service Provider Resources** link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs". Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

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

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

Medical Policy

LCD and Policy Article Revisions

Summary for August 30, 2012

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 at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A webinar will be available soon to enhance your understanding.

LCD and Policy Article Revisions

Summary for September 2012

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

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 10/01/2012

INDICATIONS AND LIMITATIONS OF COVERAGE:

- **Revised:** Cluster Headache section to include NCD 240.2.2 coverage requirements (Effective 10/01/2012)
- **Added:** Change in payment category to existing cluster headache oxygen rules
- **Revised:** Clarified home sleep testing requirements are limited to stand-alone overnight pulse oximetry
- **Revised:** Clarified that exercise testing is limited to directly supervised testing
- **Revised:** Expanded qualification testing for high liter flow to greater than or equal to 4 LPM

HCPCS CODES AND MODIFIERS:

- **Revised:** Modifier QF and QG narratives

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
- **Revised:** Refill requirements to clarify documentation of the “near exhaustion” requirement
- **Added:** Proof of delivery requirements
- **Revised:** Information requirements for documenting R&N indications

Policy Article

Revision Effective Date: 10/01/2012

CODING GUIDELINES:

- **Revised:** Cluster headache oxygen coding guideline

Note: The information contained in this article is only a summary of revisions to the LCD and Policy Article. For complete information on any topic, you must review the LCD and/or Policy Article at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A webinar will be available soon to enhance your understanding.

LCD and Policy Article Revisions

Summary for October 2012

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

Transcutaneous Electrical Nerve Stimulators (TENS) LCD

Revision Effective Date: 06/08/2012

INDICATIONS AND LIMITATIONS OF COVERAGE

AND MEDICAL NECESSITY:

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

HCPCS CODES AND MODIFIERS:

- **Added:** Q0 (zero) modifier

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY

- **Added:** Diagnosis for CLBP coverage

DOCUMENTATION REQUIREMENTS:

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

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

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

APPENDICES:

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

Wheelchair Options/Accessories

Policy Article

Revision Effective Dated: 11/01/2012

CODING GUIDELINES:

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

Note: The information contained in this article is only a summary of revisions to the LCD and Policy Article. For complete information on any topic, you must review the LCD and/or Policy Article at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A webinar will be available soon to enhance your understanding.

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

Effective for dates of service on or after June 8, 2012 TENS and related supplies used for chronic low back pain (CLBP) are only covered when the beneficiary is a participant in a CMS-approved clinical trial and has one or more required diagnoses. All other claims for TENS and related supplies used for CLBP will be denied as not reasonable and necessary. Only the following diagnoses (ICD-9) will justify coverage:

- 353.4 Lumbosacral root lesions, not elsewhere classified
- 720.2 Sacroiliitis, not elsewhere classified
- 721.3 Lumbosacral spondylosis without myelopathy
- 721.42 Thoracic or lumbar spondylosis with myelopathy – lumbar region
- 722.10 Lumbar intervertebral disc without myelopathy
- 722.52 Lumbosacral intervertebral disc
- 722.73 Intervertebral disc disorder myelopathy – lumbar region
- 722.83 Post laminectomy syndrome – lumbar region
- 722.93 Other and unspecified disc disorders, lumbar region
- 724.02 Spinal stenosis, lumbar region without neurogenic claudication
- 724.03 Spinal stenosis, lumbar region with neurogenic claudication
- 724.2 Lumbago
- 724.3 Sciatica
- 724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified, radicular syndrome of lower extremities
- 738.4 Acquired spondylolsthesis
- 739.3 Non-allopathetic lesions NEC (not elsewhere classified) – lumbar region
- 756.11 Spondylosis, lumbosacral region
- 756.12 Spondylolsthesis
- 805.4 Fracture of vertebral column without mention of spinal cord injury, lumbar, closed
- 806.4 Fracture of vertebral column with mention of spinal cord injury, lumbar, closed
- 846.0 Sprains and strains of sacroiliac region – lumbosacral (joint) (ligament)
- 846.1 Sprains and strains of sacroiliac ligament
- 847.2 Sprains and strains of other and unspecified parts of back, lumbar
- 953.2 Injury to nerve roots and spinal plexus, lumbar root

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

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

Information concerning documentation required for TENS used for CLBP may be found in the LCD at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. Also Refer to the Supplier Manual for additional information about general documentation requirements.

Ref. CR 7836

LCD and Policy Article Revisions Summary for November 1, 2012

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

Manual Wheelchair Bases LCD

Revision Effective Date: 03/01/2013

INDICATIONS AND LIMITATIONS OF COVERAGE:

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

Policy Article

Revision Effective Date: 05/01/2012

(November 2012 publication)

CODING GUIDELINES:

- **Deleted:** Wheel size requirement of E1161

Suction Pumps LCD

Revision Effective Date: 04/15/2012

(November 2012 publication)

INDICATIONS AND LIMITATIONS OF COVERAGE:

- **Revised:** Coverage for A4605 to link it as a supply to E0600
- **Revised:** Moved required diagnosis codes for A4605 and A4624 from DOCUMENTATION REQUIREMENTS section to coverage section
- **Added:** Additional ICD-9 diagnosis codes describing tracheostomy status (519.00, 519.01, 519.02, 519.09)
- **Revised:** Wound suction pump explanation about rationale for noncoverage to improve readability

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

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

DOCUMENTATION REQUIREMENTS:

- **Revised:** ICD-9 requirements for A4605 and A4624 (moved to INDICATIONS AND LIMITATIONS OF MEDICAL NECESSITY section)
- **Revised:** Updated REFILL REQUIREMENTS to include expanded description of consumable and durable supplies as separate bullets

Note: The information contained in this article is only a summary of revisions to the LCDs and Policy Article. For complete information on any topic, you must review the LCD and/or Policy Article at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A webinar will be available soon to enhance your understanding.

LCD and Policy Article Revisions

Summary for November 9, 2012

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

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 01/01/2013

(Cluster headache related items are effective 10/01/2012)

INDICATIONS AND LIMITATIONS OF COVERAGE:

- **Revised:** Long Term Oxygen Therapy Trial by creating stand-alone section and adding reference to APPENDICES section
- **Revised:** Cluster Headache section to include change to codes E0424 and E0441 and clinical study ID number information (Effective 10/01/2012)
- **Added:** Definitions for qualifying testing types to minimize confusion with other respiratory testing done for other purposes
- **Revised:** Renamed home sleep testing to be referred to as "overnight oximetry" to minimize confusion with home sleep testing done to diagnose obstructive sleep apnea
- **Added:** Clarification about supervision for testing
- **Added:** Information about when the use of polysomnogram oximetry results is acceptable to justify the reimbursement of oxygen

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

- **Added:** V70.7 as concurrent diagnosis requirement (Effective 10/01/2012)

DOCUMENTATION REQUIREMENTS:

- **Added:** Long Term Oxygen Therapy Trial section
- **Added:** "Clinicaltrials.gov" ID number requirement for long term oxygen therapy trials
- **Added:** Q0 (zero) modifier requirement to long term oxygen therapy trials
- **Added:** V70.7 instructions for cluster headache (Effective 10/01/2012)
- **Added:** "Clinicaltrials.gov" ID number requirement for cluster headache (effective 10/01/2012)

APPENDICES:

- **Added:** Clinical trials information

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

LCD

Revision Effective Date: 01/01/2013

INDICATIONS AND LIMITATIONS OF COVERAGE:

- **Revised:** Order requirement language to specify a "detailed written order"
- **Added:** Concurrent use of oxygen and PAP coverage requirements

DOCUMENTATION REQUIREMENTS:

- **Added:** Concurrent Use of Oxygen with PAP Therapy

(**Note:** The effective date above is not applicable to the documentation revisions described below. These revised and

added requirements are existing Medicare requirements which are now included in the LCD for easy reference)

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

Suction Pumps

Policy Article

Revision Effective Date: 04/15/2012

NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

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

Note: The information contained in this article is only a summary of revisions to the LCDs and Policy Article. For complete information on any topic, you must review the LCD and/or Policy Article at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A webinar will be available soon to enhance your understanding.

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

MLN Matters® Number: MM7836

Related Change Request (CR) #: CR 7836

Related CR Release Date: August 3, 2012

Effective Date: June 8, 2012

Related CR Transmittal #: R2511CP and R144NCD

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->

<http://www.cms.gov/mcd/search.asp>), 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

It saves time! I love that!



Coming in Early 2013

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.

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

MLN Matters® Number: SE1231

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: 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.

Miscellaneous

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

MLN Matters® Number: MM7729 *Revised*

Related Change Request (CR) #: CR 7729

Related CR Release Date: August 3, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R1110OTN

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.

Important Reminder About Medicare Secondary Payer Laws

MLN Matters® Number: SE1227

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: 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

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.

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

MLN Matters® Number: SE1230

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: 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

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.

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

MLN Matters® Number: SE1242

Related Change Request (CR) #: NA

Related CR Release Date: NA

Effective Date: NA

Related CR Transmittal #: NA

Implementation Date: NA

Provider Types Affected

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

What You Need to Know

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

Introduction

Annual outbreaks of seasonal flu typically occur as early as October and as late as May, with peak months in January and February. Illness from seasonal flu usually lasts one to two weeks, and flu-related complications include pneumonia and dehydration. Approximately 5 to 20 percent of Americans catch the seasonal flu each year. Getting the flu vaccine is your best protection against the flu.¹

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

Protect You and Your Family From the Flu!

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

Educational Products for Health Care Professionals

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

1. MLN Seasonal Influenza Related Products for Health Care Professionals

- **MLN Matters Article MM8047: Influenza Vaccine Payment Allowances** – Annual Update for 2012-2013 Season – This article contains the payment allowances for the 2012-2013 flu season. You can download it at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8047.pdf> on the CMS website.
- **Quick Reference Information: Medicare Part B Immunization Billing** - This educational tool is designed to provide education on Medicare-covered preventive immunizations. Available in print and as a downloadable PDF at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_immun_bill.pdf on the CMS website.
- **Quick Reference Information: Preventive Services** - This educational tool is designed to provide education on the Medicare-covered preventive services. Available as a downloadable PDF at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS_QuickReferenceChart_1.pdf on the CMS website.
- **MLN Preventive Services Educational Products Web Page** - This Medicare Learning Network® (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. View this page at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html> on the CMS website.
- **Preventive Services Educational Products PDF** – This PDF provides a list of all MLN products related to Medicare-covered preventive services. View this PDF at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/education_products_prevserv.pdf on the CMS website.

2. Other CMS Resources

- **Seasonal Influenza Vaccines 2012 Pricing** is at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2012ASPFiles.html> on the CMS website.
- **Prevention General Information Overview** is at <http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html> on the CMS website.
- **CMS Frequently Asked Questions** are available at <http://questions.cms.gov/faq.php> on the CMS website.
- **Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations** available at on the CMS website. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf> on the CMS website.
- **Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services** available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf> on the Internet.

3. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information

and tools to help increase seasonal flu vaccine awareness and utilization during the 2012 – 2013 flu season:

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

Beneficiary Information

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

Medicare Guidance Regarding Meningitis Outbreak

MLN Matters® Number: SE1246

Related Change Request (CR) #: Not Applicable

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

Provider Types Affected

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

What You Need to Know**STOP - Impact to You**

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

CAUTION – What You Need to Know

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

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

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

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

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

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

GO – What You Need to Do

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

Additional Information

If you have any questions, please contact your FI, carrier, DME MAC or A/B MAC at their toll-free number, which may be found

at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

Fees & Pricing

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

MLN Matters® Number: MM7885

Related Change Request (CR) #: CR 7885

Related CR Release Date: August 3, 2012

Effective Date: October 1, 2012

Related CR Transmittal #: R2514CP

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 OPPTS)), 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.

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

MLN Matters® Number: MM8116
 Related Change Request (CR) #: CR 8116
 Related CR Release Date: October 26, 2012
 Effective Date: January 1, 2013
 Related CR Transmittal #: R2568CP
 Implementation Date: January 7, 2013

Provider Types Affected

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

Provider Action Needed

STOP - Impact to You

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

CAUTION – What You Need to Know

Change Request (CR) 8116, from which this article is taken, instructs your Medicare Contractors to download and implement the January 2013 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), to also download and implement the revised January 2013, October 2012, July 2012, April 2012, and January 2012 files.

GO – What You Need to Do

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

Background

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

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

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

Additional Information

You can find the official instruction, CR8116, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2568CP.pdf> on the CMS website.

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

HCPSC Updates

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

MLN Matters® Number: MM8037

Related Change Request (CR) #: CR 8037

Related CR Release Date: September 7, 2012

Effective Date: January 1, 2013

Related CR Transmittal #: R2542CP

Implementation Date: January 7, 2013

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

Provider Action Needed

STOP - Impact to You

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

CAUTION – What You Need to Know

This article is based on Change Request (CR) 8037 which provides the 2013 annual update of Healthcare Common Procedure Coding System (HCPSC) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2012:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled 2013 Carrier/A/B MAC Update) will be posted at <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html> on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill Fiscal Intermediaries or A/B MACs are advised that new Excel and PDF files (entitled 2013 FI/A/B MAC Update) will be posted to <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html> on the CMS website.

GO – What You Need to Do

It is **important and necessary** for you to read the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s FI/A/B MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPSC codes.

Background

Medicare’s claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay, as well as for beneficiaries in a non-covered stay. Changes to HCPSC codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the “Medicare Claims Processing Manual,” Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Section 110.4.1 (Annual Update Process) for carriers and A/B MACs, and Section 20.6 (SNF CB Annual Update Process for Fiscal Intermediaries) for FI and A/B MACs. You can find this manual at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf> on the CMS website. Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information

The official instruction, CR8037 issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2542CP.pdf> on the CMS website.

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

News Flash Items

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 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf>) for additional guidance.

REVISED product from the Medicare Learning Network® (MLN)
“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

REVISED product from the Medicare Learning Network® (MLN)
“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

NEW products from the Medicare Learning Network® (MLN)

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

NEW products from the Medicare Learning Network® (MLN)

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

Diabetes and the Seasonal Flu - November is National Diabetes Awareness Month. Diabetes can weaken the immune system, which can put seniors and others with diabetes at greater risk for flu-related complications like pneumonia. Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries. Medicare may provide coverage of additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for the seasonal flu and pneumococcal vaccines and their administration for seniors and others with Medicare with no co-pay or deductible. And remember, seasonal flu vaccine is particularly important for health care workers, who may spread the flu to their patients. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Know what to do about the flu.

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

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

The Medicare Learning Network® (MLN) Product Ordering**System was recently upgraded to add new enhancements.**

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

Influenza Season is Around the Corner - As your patients age, their immune systems may weaken. This weakening can make seniors more susceptible to complications from seasonal influenza (flu).

Now is the perfect time to remind your patients that seasonal influenza vaccination is the best defense against the flu. Medicare provides coverage for one flu vaccine and its administration per influenza season for seniors and other Medicare beneficiaries with no co-pay or deductible. Talk with your Medicare patients about their risk for getting the flu and start protecting your patients as soon as your 2012-2013 seasonal flu vaccine arrives. Also, don't forget to immunize yourself and your staff. *Know what to do about the flu.*

Remember – Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is NOT a Part D covered drug. CMS will provide information and a link to the 2012-2013 Influenza Vaccine prices when they are available.

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

The ICD-10-related implementation date is now October 1, 2014, as announced in final rule CMS-0040-F issued on August 24, 2012.

This final rule is available at http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on the Centers for Medicare & Medicaid Services (CMS) website. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice. Keep Up to Date on ICD-10. Please visit the ICD-10 (<http://www.cms.gov/Medicare/Coding/ICD10/index.html>) website for the latest news and resources to help you prepare.

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.

REVISED product(s) from the Medicare Learning Network® (MLN) “Medicare Physician Guide,” (http://www.cms.gov/MLNProducts/downloads/MedicarePhysicianGuide_ICN005933.pdf) Guide, ICN 005933, Downloadable

Vaccinate Early to Protect Against the Flu. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And, don't forget to immunize yourself and your staff. **Get the Flu Vaccination -- Not the Flu. Remember** – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.

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

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

REVISED products from the Medicare Learning Network® (MLN) “Medicare Claim Submission Guidelines,” (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf>) Fact Sheet, ICN 906764, Downloadable

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

Registration is now open to all suppliers interested in participating in the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In order to submit a bid for the Round 1 Recompete, you must first register in the Individuals Authorized Access to the CMS Computer Services (IACS) online application. Once you have registered in IACS, you will receive a user ID and password to access the online DMEPOS Bidding System (DBidS). You must register even if you registered during a previous round of competition (Round 1 Rebid, Round 2, or the national mail-order competition). Only suppliers who have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to bid. Registration for the recompete will close on Friday, October 19, 2012 at 9pm prevailing Eastern Time. To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, <http://www.dmecompetitivebid.com>, click on Round 1 Recompete, and then click on “REGISTRATION IS OPEN” above the Registration clock. If you have any questions about the registration process, please contact the CBIC Customer Service Center at 1.877.577.5331 between 9am and 9pm prevailing Eastern Time, Monday through Friday.

On August 24, Health and Human Services (HHS) Secretary Kathleen Sebelius announced a final rule that will save time and money for physicians and other health care providers by establishing a unique Health Plan Identifier (HPID). The rule is one of a series of changes required by the Affordable Care Act to cut red tape in the health care system and will save up to \$6 billion over ten years. Currently, when a health care provider bills a health plan, that plan may use a wide range of different identifiers that do not have a standard format. As a result, health care providers run into a number of time-consuming problems, such as misrouting of transactions, rejection of transactions due to insurance identification errors, and difficulty determining patient eligibility. The change announced on August 24 will greatly simplify these processes. For more information, see the Fact Sheet (<http://www.cms.gov/apps/media/press/factsheet.asp?Content=4443&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cbOrder=date>) related to this final rule.

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 (<https://npiregistry.cms.hhs.gov/NPPERegistry/NPIRegistryHome.do>) on the CMS website.

REVISED products from the Medicare Learning Network® (MLN)

“The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers Fact Sheet,” (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_DMEPOS_FactSheet_ICN904283.pdf) ICN 904283, Downloadable only.

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 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu_Products.pdf) and Immunizations (<http://www.cms.gov/Medicare/Prevention/Immunizations/index.html>). 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.

Are you billing correctly for ordered/referred services? Will you be impacted when the Centers for Medicare & Medicaid Services (CMS) turns on the edits for these services? See the revised MLN Matters® articles SE1221 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1221.pdf>), SE1011 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1011.pdf>), and 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) and “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) to learn what you need to do.

REVISED product from the Medicare Learning Network® (MLN)

“How to Protect Your Identity Using the PECOS,” (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_ProID_FactSheet_ICN905103.pdf) Fact Sheet, ICN 905103, Downloadable only.

NEW products from the Medicare Learning Network® (MLN)

“Providing the Annual Wellness Visit (AWV),” (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AnnualWellnessVisit-ICN907786.pdf>) Booklet, ICN 907786, Downloadable

[gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AnnualWellnessVisit-ICN907786.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AnnualWellnessVisit-ICN907786.pdf)) Booklet, ICN 907786, Downloadable

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

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

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

REVISED product from the Medicare Learning Network® (MLN)

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

REVISED products from the Medicare Learning Network® (MLN)

“Advance Beneficiary Notice of Noncoverage (ABN)

Part A and Part B,” (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf) Booklet, ICN 006266, Downloadable

REVISED product from the Medicare Learning Network® (MLN)

“Preventive Immunizations,” (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Preventive-Immunizations-ICN907787.pdf>) Booklet, ICN 907787, Downloadable only.

REVISED products from the Medicare Learning Network® (MLN)

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

DME MAC Jurisdiction C Contact Information	
Contact for:	Contact Information:
EDI – Electronic Claim Submission; Electronic Remittance Notices	Jurisdiction C CEDI (toll-free): 1.866.311.9184 (8:00a - 6:00p CST, Mon. – Fri.) Jurisdiction C CEDI website: http://www.ngscedi.com E-mail: ngs.CEDIHelpdesk@wellpoint.com
Paper Claim Submission	Address: CGS PO Box 20010, Nashville, TN 37202
Provider Customer Service Calls	IVR (Interactive Voice Response): 1.866.238.9650 (Mon.-Fri., 6:00a - 8:00p CST; Sat., 6:00a - 4:00p CST) Customer Service: 1.866.270.4909 (Mon.-Fri., 7:00a - 5:00p CST) Hearing Impaired: 1.888.204.3771 (Mon.-Fri., 7:00a - 5:00p CST)
Beneficiary Customer Service Calls	Phone: 1.800.Medicare
Written Inquiries	Address: CGS PO Box 20010, Nashville, TN 37202
Claim Reopenings (Adjustments)	Address: CGS PO Box 20010, Nashville, TN 37202 Fax (for underpayments): 1.615.782.4649 Fax (for overpayments): 1.615.782.4477 Telephone requests for Reopenings: 1.866.813.7878 (8:00a - 10:30a and 12:00p – 3:30p CST)
Claim Status Inquiry & Beneficiary Eligibility	Security Access Issues/Password Reset, Email: CGS.Medicare.OPID@cgsadmin.com Enrollment Status: 1.866.270.4909
Appeals – Redetermination Requests	Address: CGS PO Box 20009, Nashville, TN 37202 Fax: 1.615.782.4630
Electronic Funds Transfer	Address: CGS Attn: EFT-DME PO Box 20010, Nashville, TN 37202
Refunds	Address: CGS DME MAC Jurisdiction C PO Box 955152, St. Louis, MO 63195-5152 Phone: 1.888.315.6930
Overnight or Special Shipping	Address: CGS DME MAC Jurisdiction C Two Vantage Way, Nashville, TN 37228
DME MAC Jurisdiction C website	website: http://www.cgsmedicare.com/jc/index.html
Advance Determination of Medicare Coverage (ADMC) - Requests	Address: CGS Attn: ADMC PO Box 20010, Nashville, TN 37202 Fax: 1.615.782.4647
Supplier Enrollment	Address: National Supplier Clearinghouse Palmetto GBA * AG-495 PO Box 100142, Columbia, SC 29202-3142 Phone: 1.866.238.9652