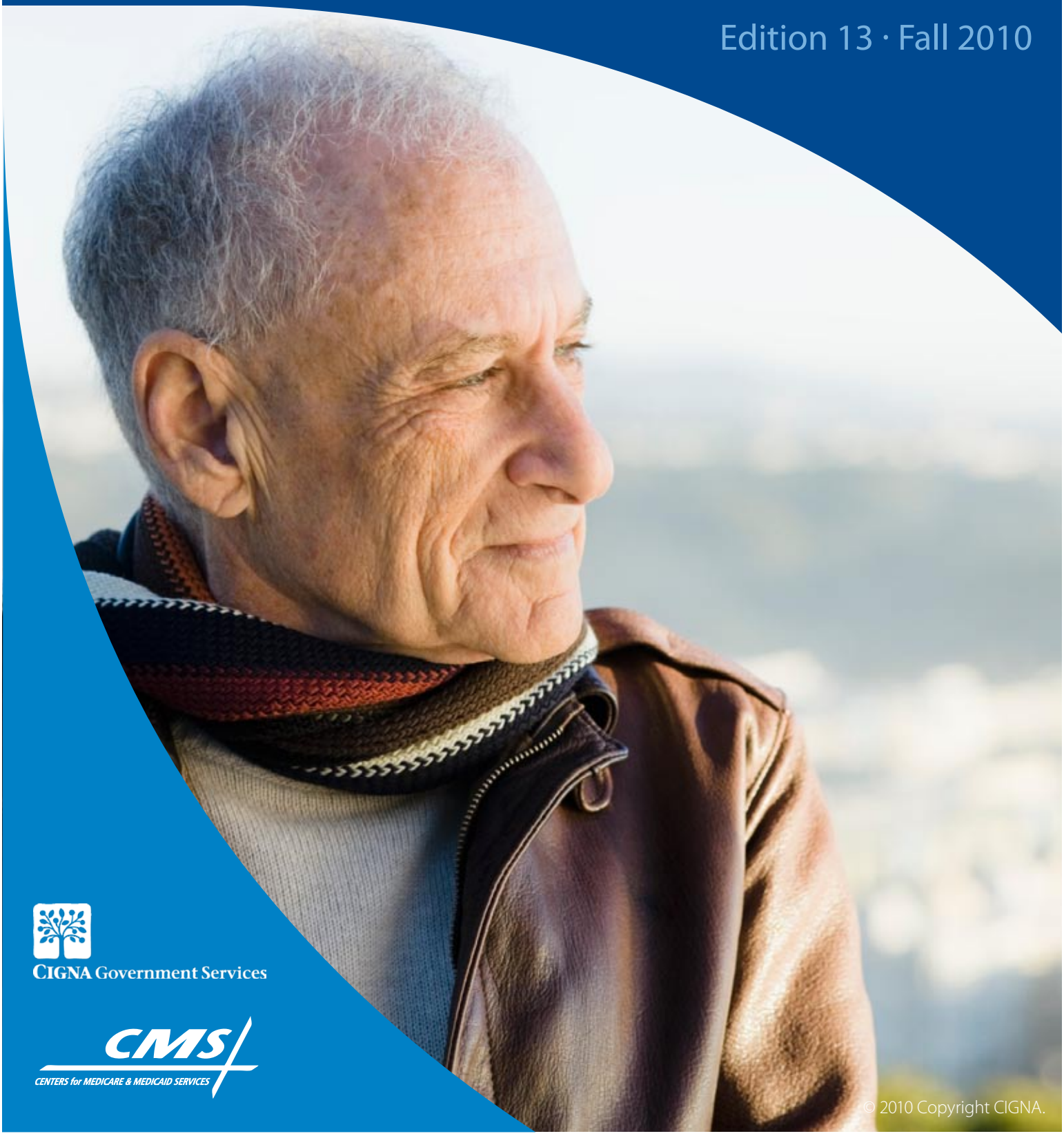
The DME MAC Jurisdiction C

INSIDER

Edition 13 · Fall 2010



CIGNA Government Services

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DME MAC Jurisdiction C
Edition 13 · Fall 2010
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Contents:

Notice: CIGNA Government Services, 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 CIGNA Government Services.

From the **Medical Director**

KX Modifier Usage Reminder

As you may have noticed, there's been a flurry of activity related to education on the proper use of the KX modifier. The Provider Outreach and Education (POE) staff have conducted webinars, created a KX modifier tool and produced a Medicare Minute segment. Why all the fuss?

The Office of Inspector General (OIG) recently published a report highlighting that a significant percentage of claims with KX modifiers did not meet the coverage requirements outlined in the local coverage determination (LCD) for the item billed. In addition, there appears to be confusion in the supplier community about the proper use of the KX modifier. As a result, CGS has produced several educational tools to assist suppliers in understanding how to correctly use the KX modifier.

CGS is considering additional activities to determine if suppliers are using the KX modifier correctly, including pre-payment review of claims. In the event a claim is selected for pre-payment review, the supplier will receive a development letter requesting documentation verifying that all policy coverage criteria are met. A copy of relevant medical records will need to be submitted to support the medical necessity for the item(s) billed.

Suppliers are reminded, however, that for any audit documentation request, the Health Insurance Portability and Protection Act (HIPAA) requires that only the "minimum necessary" information be provided. According to the 45 C.F.R. 164.502(b):

> (b) Standard: Minimum necessary — When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Therefore, in the event of a request for additional documentation to support the medical necessity for a claim, suppliers should submit only the medical documentation that supports the item or service in question. The physician, treating practitioner or supplier that is a HIPAA covered entity should make sure to redact any materials that may be contained within the medical record that are not necessary to support the billed item or service. For example, a gynecologic report would not be needed in the records submitted for a beneficiary whose clinical need for a PMD is based solely on disability secondary to a stroke.

Suppliers should review the entire policy for additional information on coding, coverage and documentation requirements by going to CMS website at http://www.cms.gov/mcd/search.asp?from2=search.asp&.

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Medical Director
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Jurisdiction C

Coverage & Billing

Break in Service Guidelines for Medicare Advantage Plan Enrollment – *Correction to the DME MAC Insider*

According to an article in the Summer 2010 DME MAC Insider, a 60-plus day enrollment in a Medicare Advantage Plan is interpreted as a break in medical need and is therefore justification to begin a new capped rental period. We have received clarification from the Centers for Medicare and Medicaid Services (CMS) that enrollment in a Medicare Advantage Plan does not result in a new capped rental period if/when the beneficiary returns to traditional Fee-For-Service Medicare. In this situation, the rental item would resume where it left off when the beneficiary joined the Medicare Advantage Plan.

Example:

- A beneficiary receives a K0001 wheelchair. The DME MAC pays for five months of rental.
- The beneficiary enrolls in a Medicare Advantage Plan (MAP) for 60-plus days. The MAP pays for rentals.
- The beneficiary then disenrolls from the MAP. The next rental claim filed to the DME MAC would be considered the sixth month of rental.

Pressure Reducing Support Surfaces - Group 3 - *Coverage Criteria Reminder*

Recently is has come to the attention of the DME MACs that there is confusion regarding the coverage of air-fluidized bed technology (Group 3 support surfaces) for patients who have undergone surgical flap or graft procedures. Medicare does not cover air-fluidized beds in the home setting for patients with surgical grafts or flaps. Coverage for patients with these conditions is outlined in the LCD for Group 2 support surfaces. Coverage of a Group 3 support surface is limited to bed-ridden or chair-bound patients with stage III or stage IV pressure ulcers that without the use of an air-fluidized bed would be institutionalized. The LCD contains additional coverage criteria including physician oversight requirements, conservative management and other provisions related to Medicare reimbursement for these products. Suppliers and physicians are encouraged to consult the LCD at http://www.cignagovernmentservices.com/jc/coverage/LCDinfo.html for full coverage, coding and documentation requirements.

Discarded Drugs and Biologicals Updates

MLN Matters® Number: MM6711 *Revised*
Related Change Request (CR) #: 6711
Related CR Release Date: April 30, 2010
Effective Date: July 30, 2010
Related CR Transmittal #: R1962CP
Implementation Date: July 30, 2010

Note: This article was revised on May 21, 2010, to clarify that your Medicare contractor may require the use of the JW modifier.

Provider Types Affected

Physicians, hospitals, suppliers and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Part A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for administering or supplying drugs and biologicals should review this article.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6711 to include in the Medicare Claims Processing Manual the updated policy, which describes when to use the JW modifier for discarded drugs.

Background

As a reminder, your Medicare contractor may require its providers to use the JW modifier. If required, when billing Medicare for all drugs except those provided under the Competitive Acquisition Program for Part B drugs and biologicals, use the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the discarded drug or biological.

For example, a single use vial labeled to contain 100 units of a drug, where 95 units are used and billed and paid on one line, the remaining 5 units will be billed and paid on another line using the JW modifier. The JW modifier is only applied to units not used. NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Additional Information

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

The official instruction, CR6711, issued to your Medicare FI, carrier, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1962CP.pdf on the CMS website.

Enhancements to Home Health (HH) Consolidated Billing Enforcement

MLN Matters® Number: MM6911 *Revised*
Related Change Request (CR) #: 6911
Related CR Release Date: June 14, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R1988CP
Implementation Date: October 4, 2010

Note: This article was revised on June 14, 2010, to reflect the revised CR 6911 that was issued on that date. In this article, the CR release date and transmittal number (see above) were revised. Also, the Web address for accessing CR 6911 was revised. All other information remains the same.

Provider Types Affected

This article may impact physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). It is also creating a new file of HH certification information to assist suppliers and providers subject to HH consolidated billing. Make sure your billing staff is aware of these changes.

What You Need to Know

Consolidated Billing Edit Modification

Non-routine supplies provided during a HH episode of care are included in Medicare's payment to the home health agency (HHA) and subject to consolidated billing edits as described in the Medicare Claims Processing Manual, chapter 10, section 20.2.1. (The revised chapter is attached to CR 6911.) If the date of service for a non-routine supply HCPCS code that is subject to HH consolidated billing falls within the dates of a HH episode, the line item was previously rejected by Medicare systems. Non-routine supply claims are submitted by suppliers on the professional claim format, which has both 'from' and 'to' dates on each line item.

When the HH consolidating billing edits were initially implemented in October 2000, the edit criteria were defined so that non-routine supply services were rejected if either the line item 'from' or 'to' date overlapped the HH episode dates. This allowed for supplies that were delivered before the HH episode began to be paid, since the prevailing practice at that time was that suppliers reported the delivery date in both the 'from' and 'to.' Medicare instructions regarding delivery of supplies intended for use over an extended period of time have since changed. Now suppliers are instructed to report the delivery date as the 'from' date and the date by which the supplies will be used in the 'to' date. When this causes the 'to' date on a supply line item subject to consolidated billing to overlap a HH episode, the service is rejected contrary to the original intent of this edit.

Effective October 1, 2010, CMS is implementing new requirements to modify this edit in order to restore the original intent to pay for supplies delivered before the HH episode began. Such supplies may have been ordered before the need for HH care had been identified, and are appropriate for payment if all other payment conditions are met. The edit will be changed to only reject services if the 'from' date on the supply line item falls within a HH episode.

A New File of HH Certification Information

Chapter 10, section 20.1 of the Medicare Claims Processing Manual describes the responsibilities of suppliers and therapy providers whose services are subject to HH consolidated billing to determine before providing their services whether a beneficiary is currently in a HH episode of care. To assist these suppliers and providers in determining this, CMS is creating an additional source of information. CMS will create a new file which will store and display certifications of HH plans of care.

Medicare coverage requirements state that all HH services must be provided under a physician-ordered plan of care. Upon admission to HH care and after every 60 days of continuing care, a physician must certify that the beneficiary remains eligible for HH services and must write specific orders for the beneficiary's care. Medicare pays physicians for this service using the following two codes:

- G0179 Physician Re-certification For Medicare-covered Home Health Services Under A Plan of Care

- G0180 Physician Certification For Medicare-covered Home Health Services Under A Plan of Care

Physicians submit claims for these services to Medicare contractors on the professional claim format separate from the HHA's billing their Request for Anticipated Payment (RAP) and claim on the institutional claim format for the HH services themselves. HHAs have a strong payment incentive to submit their RAP for a HH episode promptly in order to receive their initial 60% or 50% payment for that episode. But there may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that a HH episode will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems will display for each Medicare beneficiary the date of service for either of the two codes above when these codes have been paid. Medicare systems will allow the provider to enter an inquiry date when accessing the HH certification auxiliary file. When the provider enters an inquiry date on Medicare's Common Working File (CWF) query screens, Medicare systems will display all certification code dates within 9 months before the date entered. When the provider does not enter an inquiry date, Medicare systems will display all certification code dates within 9 months before the current date as the default response.

Note: Suppliers and providers should note that this new information is supplementary to their existing sources of information about HH episodes. Like the existing HH episode information, this new information is only as complete and timely as billing by providers allows it to be. This is particularly true regarding physician certification billing. Historically, Medicare has paid certification codes for less than 40% of HH episodes. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

Additional Information

If you have questions, please contact your Medicare RHHI/MAC at their toll-free number which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website. The official instruction (CR6911) issued to your Medicare RHHI/MAC is available at http://www.cms.gov/Transmittals/downloads/R1988CP.pdf on the CMS website.

Clarification of the Date of Service for Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010

MLN Matters® Number: MM6990
Related Change Request (CR) #: 6990
Related CR Release Date: June 8, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R717OTN
Implementation Date: July 9, 2010

Provider Types Affected

This article is for suppliers submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (MAC) and/or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for oxygen services provided to Medicare beneficiaries.

What You Need to Know

CR 6990, from which this article is taken, clarifies (effective July 1, 2010) the date of service (DOS) of an oxygen equipment maintenance and servicing visit as discussed in CR 6792 (Maintenance and Servicing Payments for Certain Oxygen Equipment After July 1, 2010).

In particular, please note one element of this clarification, i.e., CR 6990 requires that the applicable date of Service (DOS) must be at least 6 months after the 36-month rental cap for oxygen equipment or the end of the warranty period for maintenance and servicing, whichever is later. Further, before a supplier can bill for maintenance and servicing, the supplier must verify and document in their records that the oxygen equipment is no longer covered under a warranty and the supplier must visit the beneficiary's home to inspect the equipment.

Please see the background section, below, for additional information; and you should make sure that your billing staffs are aware of these clarifications.

Background

CR 6792 (released on February 5, 2010) announced (for dates of service on or after July 1, 2010) that Medicare regulation 42 CFR 414.210(e) (5) permits one payment for all maintenance and servicing of certain oxygen equipment during each 6-month period, beginning 6 months after the end of the 36-month rental period for oxygen equipment. (You can find the associated MLN Matters® article at http://www.cms.gov/MLNMattersArticles/downloads/MM6792.pdf on the CMS website.)

Medicare contractors and durable medical equipment (DME) suppliers requested clarification for particular situations that are listed below, and CR 6990 (from which this article is taken) provides that clarification.

This clarification in date of service (DOS) applies to the following oxygen concentrators and oxygen transfilling equipment, HealthCare Common Procedure Coding System (HCPCS) codes:

- **E1390 –** Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate;
- **E1391 –** Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each;
- **E1392 –** Portable oxygen concentrator, rental;
- **E0433 –** Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge; and
- **K0738 –** Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes

portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing.

It does not apply to beneficiary-owned oxygen equipment or to the following liquid and gaseous oxygen equipment HCPCS codes:

- **E0424 –** Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing;
- **E0431 –** Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing;
- **E0434 –** Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing; or
- **E0439 –** Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing.

CR 6990 clarifies the following situations

1. **Date of Service for Multiple Visits**
   If multiple maintenance and servicing visits are needed, the DOS is the date of the first visit in the first month of the 6-month period during which an in home inspection of the equipment was performed.
2. **Date of Service for Delayed Visits**
   If an unavoidable delay (e.g., hospitalization of the beneficiary or beneficiary is out of the service area) causes the DOS to occur after the first month of a 6-month period, the DOS is the date of the first visit after the delay during which an in home inspection of the equipment was performed. The reason for the unavoidable delay must be documented by the supplier and maintained in the supplier's records. Payment for subsequent maintenance and servicing visits can occur no earlier than 6 months after the DOS of the delayed visit (i.e., the last visit date used to bill for the maintenance and servicing payment). As a result, a new sequence of 6 month periods for maintenance and service payment is established.
3. **Date of Service for Multiple Pieces of Oxygen Equipment**
   If both a stationary concentrator and portable transfilling equipment are serviced, and the 36-month rental payment cap for one piece of equipment was reached at a different time than the 36-month rental payment cap for the other piece of equipment, the DOS is the date of the visit which occurs during the 6-month period following the earliest of the dates that the 36-month rental caps was reached for either piece of equipment. Only one payment is allowable per beneficiary regardless of the number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment).
4. **Date of Service When a Maintenance and Servicing Warranty Applies**
   The applicable DOS must be at least 6 months after the 36-month rental cap for oxygen equipment or the end of the warranty period for maintenance and servicing, whichever is later.

Please remember that only one maintenance and servicing payment may be made for each 6-month period, regardless of the combination of stationary and portable oxygen equipment that the beneficiary uses. In addition, payment for maintenance and servicing cannot be made if the oxygen equipment is covered under a warranty; therefore, before you can bill for maintenance and servicing, you must confirm, and record, that the oxygen equipment is no longer covered under a warranty; and visit the beneficiary's home to inspect the equipment.

Finally, keep in mind that the Medicare Claims Processing Manual, Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)), Section 40 (Payment for Maintenance and Service for Non-ESRD Equipment), Subsection 40.1 (General) instructs your contractor to refer cases to the program integrity specialist if claims are submitted that do not appear to comply with program instructions.

For reference, a summary of service details from CR 6792 follows:

1. If a combination of stationary concentrator (E1390 or E1391) and transfilling equipment (K0738 or E0433) is furnished, the supplier should bill for the maintenance and servicing payment using the code for the concentrator (E1390 or E1391) and the MS modifier.
2. If a portable concentrator (billed using a combination of codes E1390 and E1392 during the 36-month rental period) is furnished, the supplier should bill for the maintenance and servicing payment using the code for the concentrator (E1390 or E1391) and the MS modifier.
3. Code E1392 should not be used when billing for maintenance and servicing.
4. If transfilling equipment (K0738 or E0433) is furnished and a separate concentrator is not furnished or is owned by the beneficiary, the supplier should bill for the maintenance and servicing payment using the code for the transfilling equipment (K0738 or E0433) and the MS modifier.
5. Also, only one maintenance and servicing payment may be made for each 6-month period, regardless of the number of visits. Although a visit is not required, separate payment is not allowable without an in home visit to inspect the equipment. Even if the supplier does not perform a maintenance and servicing visit and forgo payment, 42 CFR 414.226(f)(1) continues to require the supplier that furnished the oxygen equipment for the 36th continuous rental month to furnish the equipment in good working order for the remaining period of medical need or the end of the equipment's reasonable useful lifetime (5 years).

Additional Information

You can find the official instruction, CR 6990, issued to your RHHI, MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R717OTN.pdf on the CMS website.

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

Glucose Monitors and Supplies

Dear Physician:

Glucose monitor supplies have consistently been one of the highest sources of errors in medical reviews performed by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Comprehensive Error Rate Testing (CERT) contractor. It is your responsibility as the ordering physician to determine and document the medical necessity for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items. The following information is intended to provide you with guidance on Medicare's coverage and documentation requirements for glucose monitors and testing supplies.

Coverage

Glucose monitors and related supplies are covered for patients with diabetes (ICD-9 Codes 249.00 – 250.93) if they or their caregiver can be trained to use the prescribed device appropriately. The Glucose Monitors Local Coverage Determinations (LCDs) of the DME MACs define the quantity of test strips and lancets that are covered, if the basic criterion above is met.

Treatment regimen	Basic coverage - Test strips and lancets	Average testing
Insulin treated	100 per month	3x per day
Non-insulin treated	100 per 3 months	1x per day

Additional quantities of test strips can be considered for coverage **if they are deemed medically necessary** – see following section. Coverage is also provided for a lancing device, calibration solution, and replacement batteries.

Medical Necessity Documentation

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers (unless specifically requested of the supplier by the DME MAC).

There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and,
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
  - Justification for testing frequency; and,
  - Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:

- Names, dosages, and timing of administration of medications used to treat the diabetes;
- Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
- Review of beneficiary-maintained log of glucose testing values;
- Changes in the patient's treatment regimen as a result of glucose testing results review;
- Dosage adjustments that the patient should make on their own based on selftesting results;
- Laboratory tests indicating level of glycemic control (e.g., hemoglobin A1C);
- Other therapeutic interventions and results.

Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

- Documentation by the beneficiary of the actual frequency of testing.
  - Logs of self-testing values including the date, time, and results
  - Information about medication dosage adjustments related to the results is also helpful.

Orders

There must be a written order for all testing supplies. The written order must contain the following elements:

1. Item(s) to be dispensed;
2. Frequency of testing ("as needed" is not acceptable);
3. Physician's signature;
4. Signature date;
5. Start date of order – only required if start date is different than signature date.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing, a change in supplier, or a new treating physician.

Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

This article is only intended to be a general summary. It is not intended to take the place of the written law, regulations, national or local coverage determinations. The LCD for Glucose Monitors can be found in the Medicare Coverage Database on the CMS web site at http://www.cms.gov/mcd/search.asp?from2=search.asp& (search "Glucose Monitors").

Sincerely,

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Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

MLN Matters Number: MM7006
Related Change Request (CR) #: 7006
Related CR Release Date: July 2, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R1996CP
Implementation Date: October 4, 2010

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment MACs (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

This article is based on Change Request (CR) 7006, which reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) website at http://www.cdc.gov/nchs/icd9.htm in June of each year. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Background

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 7006 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2010 (for institutional providers, effective for discharges on or after October 1, 2010).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims. However, an ICD-9-CM code is not required for ambulance supplier claims.

Additional Information

For complete details regarding this CR, please see the official instruction (CR7006) issued to your Medicare contractor, which may be found at http://www.cms.gov/Transmittals/downloads/R1996CP.pdf on the CMS website.

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

Medicare Coverage of Blood Glucose Monitors and Testing Supplies

MLN Matters® Number: SE1008 *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

Provider Types Affected

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

What You Need to Know

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to remind providers what blood glucose self-testing equipment and supplies are covered for Medicare beneficiaries. In addition, prescription/order requirements, quantities and frequency limits of supplies, and documentation requirements for the beneficiary's medical record are detailed. This article reinforces information supplied in MLN Matters® article SE0738, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0738.pdf on the Centers for Medicare & Medicaid Services (CMS) website. This article is informational only and represents no Medicare policy changes.

Background

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies. Medicare provides coverage of blood glucose monitors and associated accessories and supplies for insulin-dependent and non-insulin

dependent diabetics based on medical necessity. For more information regarding medical necessity, see the section below titled 'Providing Evidence of Medical Necessity.'

Diabetes (diabetes mellitus) is defined as a condition of abnormal glucose metabolism using the following criteria:

- A fasting blood glucose greater than or equal to 126 mg/dL on two different occasions;
- A 2 hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or
- A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

See the Medicare Benefit Policy Manual, Chapter 15, at http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf on the CMS website for more information.

Coverage for diabetes-related Durable Medical Equipment (DME) is provided as a Medicare Part B benefit, and the Medicare Part B deductible and coinsurance or copayment applies. If the provider or supplier does not accept assignment, the amount the beneficiary pays may be higher. In this case, Medicare will provide payment of the Medicare-approved amount to the beneficiary.

Prescribing/Ordering a Blood Glucose Monitor and Associated Accessories

Provider Requirements

For Medicare coverage of a blood glucose monitor and associated accessories, the provider must provide a valid prescription (order) which must state to the supplier:

1. The item(s) to be dispensed;
2. The frequency of testing ("as needed" is not acceptable);
3. The physician's signature;
4. The signature date; and
5. The start date of the order – only required if the start date is different than the signature date.

For beneficiaries who are insulin-dependent, Medicare provides coverage for up to 100 test strips and lancets every month, and one lancet device every 6 months.

For beneficiaries who are non-insulin dependent, Medicare provides coverage for up to 100 test strips and lancets every 3 months, and one lancet device every 6 months.

Note: Medicare allows additional test strips and lancets if deemed medically necessary. See the section below titled 'Providing Evidence of Medical Necessity.' Medicare will not pay for any supplies that are not requested or were sent automatically from suppliers, even if the beneficiary has "authorized" this in advance. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven (7) days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the item(s) no sooner than approximately five (5) days prior to the end of usage for the current product(s). This includes lancets, test strips, and blood glucose monitors.

CR 2363 (Transmittal B-03-004) states that glucose test strips and supplies can be billed for up to 3 months of supplies at a time. Beginning April 1, 2002, claims for test strips and supplies must be submitted with the appropriate "start" and "end" dates. The "start" and "end" dates for each claim can span across 3 months. You can find CR 2363 at http://www.cms.hhs.gov/Transmittals/Downloads/B03004.pdf on the CMS website.

Suppliers may dispense most items of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) based on a verbal order or preliminary written order from the treating physician. This dispensing order must include: a description of the item, the beneficiary's name, the physician's name and the start date of the order. Suppliers must maintain the preliminary written order or written documentation of the verbal order and this documentation must be available to Medicare contractors upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is non-covered. See the Medicare Program Integrity Manual, Chapter 5, at http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf on the CMS website.

For verbal orders, the physician must sign and return to the supplier a written, faxed, or electronic confirmation of the verbal order. On this confirmation the item(s) to be dispensed, frequency of testing, and start date (if applicable) may be written by the supplier, but the confirmation must be reviewed, signed, and dated by the physician. Physicians should inspect these written confirmations carefully. Suppliers must not add unrelated items to the detailed written order, whether requested by the beneficiary or not, in the absence of a dispensing order from the physician for that item.

A new order for diabetic testing supplies is required only if there is a change in the frequency of testing or a change in supplier. Renewal orders must contain the same information as initial orders and be submitted to the supplier using one of the methods acceptable for initial orders.

CMS expects that physician records will reflect the care provided to the patient including, but not limited to, evidence of the medical necessity for the prescribed frequency of testing. Physicians are not required to fill out additional forms from suppliers or to provide additional information to suppliers unless specifically requested of the supplier by the DME MAC. For more information regarding evidence of medical necessity, see the section below titled 'Providing Evidence of Medical Necessity."

Note: CR 5971 (Transmittal 248) was issued to prohibit the use of stamped signatures. In addition, Medicare requires a legible identifier for services provided/ordered as outlined in CR 6698 (Transmittal R327PI). The method used should be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. You can review MLN Matters® articles related to CR 5971 and CR 6698 at http://www.cms.gov/MLNMattersArticles/downloads/MM5971.pdf and http://www.cms.gov/mlnmattersarticles/downloads/mm6698.pdf on the CMS website.

Home Blood Glucose Monitors

There are several different types of blood glucose monitors that use reflectance meters to determine blood glucose levels. Medicare coverage of these devices varies, with respect to both the type of device and the medical condition of the patient for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as DME for use in the home because their need for frequent professional re-calibration makes them unsuitable for home use.

However, some types of blood glucose monitors which use a reflectance meter specifically designed for home use by diabetic patients may be covered as DME, subject to the conditions and limitations described below.

Blood glucose monitors are meter devices that read color changes produced on specially treated reagent strips by glucose concentrations in the patient's blood. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and (following instructions which may vary with the device used), inserts it into the device to obtain a reading.

Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for patients for whom the device is indicated.

Home blood glucose monitors enable certain patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment. Studies indicate that the patient's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to patients who must make frequent checks of their blood glucose levels.

Accordingly, coverage of home blood glucose monitors is limited to patients meeting the following conditions:

1. The patient has been diagnosed as having diabetes;
2. The patient's physician states that the patient is capable of being trained to use the particular device prescribed in an appropriate manner.
   In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to assure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician; and
3. The device is designed for home use rather than clinical use.

There are also blood glucose monitoring systems designed especially for use by those with visual or manual dexterity impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable patients with visual or manual dexterity impairment to use the equipment without assistance.

These special blood glucose monitoring systems are covered under Medicare if the following conditions are met:

- The patient and device meet the three conditions listed above for coverage of standard home blood glucose monitors; and
- The patient's physician certifies that the beneficiary has a visual or manual dexterity impairment severe enough to require use of this special monitoring system. Note: Section 1833(e) of the Social Security Act precludes payment to any provider of services "unless there has been furnished such information as may be necessary in order to determine the amounts due such provider…" See http://www.socialsecurity.gov/OP_Home/ssact/title18/1833.htm on the Internet.

For more information on home blood glucose monitors, including additional requirements for monitors with special features, see the Medicare National Coverage Determinations Manual, Chapter 1, Part 1 (Coverage Determinations), Section 40.2 (Home Blood Glucose Monitors) at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf on the CMS website and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at http://www.cms.gov/mcd/search.asp?from2=search.asp& (search "Glucose Monitors").

The Health Care Common Procedure Coding System (HCPCS) codes used to report blood glucose self-testing equipment and supplies are shown in the following table:

HCPCS Codes for Blood Glucose Self-Testing Equipment and Supplies	
HCPCS Code	**HCPCS Code Descriptor**
A4233	Alkaline battery for glucose monitor
A4234	J-cell battery for glucose monitor
A4235	Lithium battery for glucose monitor
A4236	Silver oxide battery glucose monitor
A4253	50 test strips for a blood glucose monitor
A4256	Calibration solutions
A4258	Spring-powered lancing device
A4259	100 lancets for a blood glucose monitor
E0607	Home blood glucose monitor
E2100	Home blood glucose monitor w voice capability (for visual impairment)
E2101	Home blood glucose monitor w integrated lancing/blood collection (for manual dexterity impairment)

Providing Evidence of Medical Necessity

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). There are several critical issues to address in the patient's medical record related to medical necessity for glucose testing supplies:

- Basic coverage criteria for the glucose monitor and any related supplies; and
- If ordering quantities of test strips and lancets that exceed the quantities specified in the LCD:
  - Justification for testing frequency; and
  - Evidence of the patient's use of the testing supplies.

To satisfy the requirements for the basic coverage criteria, the patient's medical record should provide information about the following elements:

- Diagnosis
- Treatment regimen (insulin treated versus non-insulin treated)
- Education of the patient or caregiver on the use of the glucose monitor

To support coverage for quantities of supplies that exceed the limits specified in the LCD, there must be:

- Documentation by the physician in the patient's medical record of the necessity for the higher frequency of testing. This may include some of the following elements:
  - Names, dosages, and timing of administration of medications used to treat the diabetes;
  - Frequency and severity of symptoms related to hyperglycemia and/or hypoglycemia;
  - Review of beneficiary-maintained log of glucose testing values;
  - Changes in the patient's treatment regimen as a result of glucose testing results review;
  - Dosage adjustments that the patient should make on their own based on self-testing results;
  - Laboratory tests indicating level of glycemic control (e.g., Hemoglobin A1C);
  - Other therapeutic interventions and results;
- Documentation by the beneficiary of the actual frequency of testing.
  - Logs of self-testing values including the date, time, and results
  - Information about medication dosage adjustments related to the results is also helpful.

Not every patient medical record will contain all of these elements; however, there must be enough information in the patient's medical record to support the medical necessity for the quantity of item(s) ordered and dispensed.

For more information regarding evidence of medical necessity, see the Medicare Program Integrity Manual, Chapter 5 (Items and Services Having Special DME Review Considerations) at http://www.cms.hhs.gov/manuals/downloads/pim83c05.pdf on the CMS website, and the Medicare Coverage Database for the local coverage determination (LCD) applicable to your area at http://www.cms.gov/mcd/search.asp?from2=search.asp& (search "Glucose Monitors").

Additional Information

You can find SE0738, An Overview of Medicare Covered Diabetes Supplies and Services at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0738.pdf on the CMS website.

You can also find The Guide to Medicare Preventive Services at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_Web-061305.pdf and the Medicare Preventive Services Brochure at http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf on the CMS website.

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

ICD-10 Implementation Information

MLN Matters® Number: SE1019
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 issue impacts 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 provides 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 first ICD-10-related compliance date is less than 2 years away. On January 1, 2012, standards for electronic health transactions change from Version 4010/4010A1 to Version 5010. Unlike Version 4010, Version 5010 accommodates the ICD-10 code structure. This change occurs before the ICD-10 implementation date to allow adequate testing and implementation time.

On October 1, 2013, 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, 2013, the Centers for Medicare & Medicaid Services (CMS) will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures), replacing the ICD-9-CM diagnosis and procedure code sets.

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

Important, please be aware:

- ICD-9-CM codes will not be accepted for services provided on or after October 1, 2013.
- ICD-10 codes will not be accepted for services prior to October 1, 2013.

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, 2013, and for all diagnoses on claims for inpatient settings with dates of discharge that occur on or after October 1, 2013.

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, 2013.

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). For example:
- 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. Go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage on the CMS website. Scroll to the bottom of the web page to the Downloads section and select the 2010 ICD-10 Conference Calls zip file and locate the March 23rd written or audio transcript.

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/ICD10 (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". Go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp, scroll to the bottom of the page, under Downloads select – 2009 ICD-10 Conference Calls to locate the audio and written transcripts.

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

- 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/ICD10 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/ICD10/06_MedicareFeeforServiceProviderResources.asp 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/ICD10/02c_CMS_Sponsored_Calls.asp#TopOfPage 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/ICD10/, 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

External Infusion Pump LCD Immune Globulin Subcutaneous (Human), 20% Liquid (Hizentra™)

A new subcutaneous immune globulin (SCIG) preparation, Immune Globulin Subcutaneous (Human), 20% Liquid (Hizentra™), has been approved for use by the Food and Drug Administration. This preparation meets the requirements necessary for inclusion in the DME MAC External Infusion Pump LCD as a covered SCIG when used for the treatment of primary immune deficiency disease. Coverage is effective for claims with dates of service on or after March 4, 2010.

Claims for Hizentra™ administered with a DME infusion pump should be submitted using HCPCS code:

J7799 NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME

Hizentra™ is supplied in 5ml (1g protein), 10 ml (2g protein), and 20 ml (4g protein) vials. One unit of service equals 5 ml (1g protein). Since the amount of SCIG for each patient is individualized, each dose must be prepared using the combination of vial sizes that result in the least amount of wastage for the dosage amount being administered.

An E0779 infusion pump is covered for the administration of subcutaneous immune globulin.

Refer to the External Infusion Pump LCD for additional information about the coverage of SCIG. Hizentra™ will be added to a future revision of the LCD.

Immunosuppressive Drugs Everolimus (Zortress®)

The Food and Drug Administration has approved the use of everolimus (Zortress®) tablets as prophylaxis for rejection of organ transplants. Coverage is effective for claims with dates of service on or after April 20, 2010.

Everolimus is supplied as tablets, 0.25 mg, 0.5 mg, and 0.75 mg. Until such time as an individual HCPCS code is designated, claims should be billed using HCPCS code J7599 IMMUNOSUPPRESSIVE DRUG, NOT OTHERWISE CLASSIFIED. One unit of service is 0.25 mg.

As indicated in the Immunosuppressive Drugs LCD, "(When) code J7599 is billed, the claim must list the name of the drug, the dosage strength, number dispensed and administration instructions."

Refer to the Immunosuppressive Drugs LCD http://www.cignagovernmentservices.com/jc/coverage/LCDinfo.html for modifier and additional coverage requirements. Everolimus will be added to a future revision of the LCD.

Lessons Learned: E0601 – Continuous Airway Pressure Device

CIGNA Government Services' Medical Review staff recently completed a widespread probe review of HCPCS code E0601 post payment claims. The sample consisted of 100 randomly selected claims paid between October 1, 2009 and December 31, 2009. The claims were submitted by 96 different suppliers.

The widespread probe review was conducted because Jurisdiction C's analysis of billing data showed that suppliers might be billing inappropriately for E0601 services. The PAP policy group ranks #7 in Comprehensive Error Rate Testing (CERT) errors accounting for 3.8% of sample dollars paid in error.

Additionally, there has been a recent change in both the National Coverage Determination (NCD) and Local Coverage Determination (LCD). This change created coverage for the use of home portable monitors to diagnose obstructive sleep apnea but also added criteria for physician evaluations and assessment of benefit from therapy.

The following information provides a summary of the scope of the review and the significant findings.

Delivery Documentation

- The delivery documentation was checked for the following elements:
- Beneficiary's name
- Detailed description of items (manufacturer, model, serial number, etc.)
- Date of delivery
- Signature of person accepting delivery and signature date
- 5 of the 100 claims did not include delivery documentation

Detailed Written Order

- The detailed written order was checked for the following elements:
  - Beneficiary's name
  - Order for CPAP
  - Pressure settings
  - List of all items separately billed
  - Refill/replacement instructions
  - Length of need
  - Treating physician's signature
  - Physician's signature date (personally entered by physician)
  - Start date of the order
- Claim history was also checked to make sure that the written order was obtained prior to billing and the signature was checked to make sure it met CMS signature requirements.
- The following deficiencies were found in regards to detailed written orders:
  - **7 claims** – no written order in the file
  - **17 claims** – order did not list all separately billed items
  - **69 claims** – order did not include refill/replacement instructions
  - **12 claims** – length of need was not on the order
  - **1 claim** – no physician signature
  - **4 claims** – no physician signature date or the date was not personally entered by the physician
  - **2 claims** – the detailed written order was not obtained prior to billing
  - **1 claim** – the signature did not meet CMS signature requirements
  - 2 claims – no written order other than a CPAP CMN which is a retired form and therefore cannot serve in lieu of a written order

Medical Necessity for CPAP Therapy

Suppliers were asked to submit medical records to support that coverage criteria were met. The findings are as follows:

- **6 claims –** no medical records submitted
- **19 claims –** the file did not include a face-to-face clinical evaluation conducted by the treating physician prior to the sleep test that assessed the patient for OSA (or, for dates of service prior to 11/01/2008, a clinical evaluation performed prior to initiation of CPAP therapy that supported a diagnosis of OSA)
- **12 claims –** the physician's signature on the clinical evaluation did not meet CMS signature requirements
- **10 claims –** no sleep test provided
- **4 claims –** the sleep test documented an AHI/RDI between 5 and 14 events/hour but the medical records did not confirm that the beneficiary had excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; OR hypertension, ischemic heart disease, or history of stroke
- **1 claim –** the sleep test was conducted by the CPAP supplier
- **8 claims –** the physician's signature on the sleep test did not meet CMS signature requirements

Patient/Caregiver Education

The coverage criteria include a requirement that the supplier instruct the beneficiary and/or caregiver in the proper care of the CPAP device and accessories. Twelve (12) of the claims in the sample did not include documentation that verified that this requirement was met.

Proof of Adherence to Therapy

Continued coverage of a CPAP device beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from CPAP therapy.

For CPAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

10. Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and,
11. Objective evidence of adherence to use of the CPAP device, reviewed by the treating physician.

Adherence to therapy is defined as use of CPAP ≥4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

- **26 claims –** the file did not include a clinical re-evaluation conducted by the treating physician between the 31st and 91st day after initiating therapy
- **9 claims –** the re-evaluation did not document that the beneficiary's symptoms of OSA improved with the use of CPAP therapy
- **13 claims –** the re-evaluation did not confirm that the treating physician reviewed the objective evidence of adherence to use of the CPAP device
- **6 claims –** the physician's signature on the re-evaluation did not meet CMS signature guidelines
- **23 claims –** the file did not include objective proof of adherence to therapy (or, for initial dates of service prior to 11/01/2008, proof that the beneficiary was benefiting from therapy)
- **14 claims –** the adherence to therapy report did not verify that the beneficiary was using the device > 4 hours per night on 70% of nights during a consecutive 30 day period

In summary, the widespread probe review showed that suppliers are not following published Medicare guidelines and policies in submitting claims for necessary and reasonable HCPCS code E0601 services. The calculated error rate (determined by dividing the dollar amount of services paid in error by the dollar amount of services medically reviewed) was 63.94%.

Suppliers are encouraged to utilize the educational materials available on the CGS DME MAC Jurisdiction C website (http://www.cignagovernmentservices.com/jc) to make sure the services they bill meet Medicare guidelines. Online education resources for PAP devices include:

- FAQs (http://www.cignagovernmentservices.com/jc/pubs/news/2009/0909/cope10618B.html)
- Documentation Checklists (http://www.cignagovernmentservices.com/jc/coverage/MR/DocumentationChecklists.html)
- 3-part video series present by Dr. Robert Hoover, the Jurisdiction C DME MAC Medical Director (http://www.cignagovernmentservices.com/jc/education/Video/index.html)

Therapeutic Shoes – In-Person Fitting and Delivery

Appendix C of the DMEPOS Quality Standards published in October 2008 addresses specific requirements for orthoses, prostheses, prosthetic devices, and therapeutic shoes. Those standards include requirements for "an in-person diagnosis-specific functional clinical examination" by the supplier to determine the need for a particular item as well as "face-to-face fitting/delivery" by the supplier. Therefore, in order for therapeutic shoes, inserts, and shoe modifications to be covered, both of the following criteria must be met:

1. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient; and,
2. At the time of delivery of the items selected, the supplier must conduct and document an in-person visit with the patient to ensure that the shoes/inserts/modifications are properly fit and meet the beneficiary's needs.

In order to meet these criteria, effective for claims with dates of service on or after July 1, 2010, the following documentation requirements must be met:

- The in-person evaluation prior to selecting the items must include at least an examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications. For all shoes, it must include taking measurements of the patient's feet. For custom molded shoes (A5501) and inserts (A5513), this visit must also include 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.
- The in-person visit at the time of delivery must include an assessment of the fit of the shoes and inserts with the patient wearing them.

Depending on the items ordered, both the evaluation and delivery could occur on the same day if the supplier had both a sufficient array of sizes and types of shoes/inserts and adequate equipment on site to provide the items that meet the beneficiary's needs. Both components of the visit (criteria 1 and 2, above) must be clearly documented.

Documentation of these visits must be available to the DME MAC, ZPIC, RAC, or CERT contractor on request. If one or more of these requirements are not met, the claim will be denied as statutorily noncovered.

This information will be incorporated in a future revision of the Therapeutic Shoes policy. Refer to the Therapeutic Shoes Local Coverage Determination and Policy Article at http://www.cignagovernmentservices.com/jc/coverage/LCDinfo.html for additional information regarding coverage, coding, and documentation.

Medical Review

Signature Guidelines for Medical Review Purposes

MLN Matters® Number: MM6698 *Revised*
Related Change Request (CR) #: 6698
Related CR Release Date: March 16, 2010
Effective Date: March 1, 2010
Related CR Transmittal #: R327PI
Implementation Date: April 16, 2010

Note: This article was revised on June 16, 2010 to include on pages 6-7 a table excerpted from CR 6698 that summarizes signature requirements. All other information is the same.

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6698 to clarify for providers how Medicare claims review contractors review claims and medical documentation submitted by providers. CR 6698 outlines the new rules for signatures and adds language for E-Prescribing. See the rest of this article for complete details. These revised/new signature requirements are applicable for reviews conducted on or after the implementation date of April 16, 2010. Please note that all signature requirements in CR 6698 are effective retroactively for Comprehensive Error Rate Testing (CERT) for the November 2010 report period.

Background

Those contractors who review Medicare claims include MACs, Affiliated Contractors (ACs), the CERT contractors, Recovery Audit Contractors (RACs), Program Safeguard Contractors (PSCs), and Zone Program Integrity Contractors (ZPICs). These contractors are tasked with measuring, detecting, and correcting improper payments as well as identifying potential fraud in the Fee for Service (FFS) Medicare Program.

The previous language in the Program Integrity Manual (PIM) required a "legible identifier" in the form of a handwritten or electronic signature for every service provided or ordered. CR 6698 updates these requirements and adds E-Prescribing language.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. There are some exceptions, i.e.:

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 and the Medicare Benefit Policy Manual, chapter 15, section 80.6.1, state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (e.g., a progress note) that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD and CMS manuals are silent on whether the signature be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed below to discern the identity and credentials (e.g.MD, RN) of the signator. In cases where the relevant regulation, NCD, LCD and CMS manuals have specific signature requirements, those signature requirements take precedence.

The AC, MAC and CERT reviewers shall apply the following signature requirements:

If there are reasons for denial unrelated to signature requirements, the reviewer need not proceed to signature authentication. If the criteria in the relevant Medicare policy cannot be met but for a key piece of medical documentation which contains a missing or illegible signature, the reviewer shall proceed to the signature assessment.

Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead may make use of the signature authentication process.

Keep in mind that a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and note the following:

- If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.
- If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.
- If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation from the author of the medical record entry.

The following are the signature requirements that the ACs, MACs, RACs, PSCs, ZPICs, and CERT contractors will apply:

- Other regulations and CMS instructions regarding signatures (such as timeliness standards for particular benefits) take precedence.
- Definition of a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation.

- For medical review purposes, if the relevant regulation, NCD, LCD, and other CMS manuals are silent on whether the signature must be dated, the reviewer shall review to ensure that the documentation contains enough information for the reviewer to determine the date on which the service was performed/ ordered. EXAMPLE: The claim selected for review is for a hospital visit on October 4. The Additional Documentation Request (ADR) response is one page from the hospital medical record containing three entries. The first entry is dated October 4 and is a physical therapy note. The second entry is a physician visit note that is undated. The third entry is a nursing note dated October 4. The reviewer may conclude that the physician visit was conducted on October 4.
- **Definition of a Signature Log:** Providers will sometimes include, in the documentation they submit, a signature log that identifies the author associated with initials or an illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers will consider all submitted signature logs regardless of the date they were created.
- **Definition of an Attestation Statement:** In order for an attestation statement to be considered valid for Medicare medical review purposes, the statement must be signed and dated by the author of the medical record entry and contain the appropriate beneficiary information.
- Providers will sometimes include in the documentation they submit an attestation statement. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

  I, _____[print full name of the physician/ practitioner]____, hereby attest that the medical record entry for _____[date of service]____ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]____ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

- While this sample statement is an acceptable format, at this time, CMS is neither requiring nor instructing providers to use a certain form or format. A general request for signature attestation shall be considered a non-standardized follow-up question from the contractors to the providers so long as the contractors do not provide identical requirements or suggestions for the form or format of the attestation. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. However, once OMB has assigned an OMB Paperwork Reduction Act number to this attestation process, a certain form/format will be mandatory.
- Claims reviewers will not consider attestation statements where there is no associated medical record entry or from someone other than the author of the medical record entry in question. Even in cases where two individuals are in the same group, one may not sign for the other in medical record entries or attestation statements.
- If a signature is missing from an order, claims reviewers will disregard the order during the review of the claim.
- Reviewers will consider all attestations that meet the guidelines regardless of the date the attestation was created, except in those cases where the regulations or policy indicate that a signature must be in place prior to a given event or a given date.
- The following are the signature guidelines in section 3.4.1.1.B.c as shown in the manual revision attachment of CR 6698:
  - In the situations where the guidelines indicate **"signature requirements met,"** the reviewer will consider the entry.
  - In situations where the guidelines indicate **"contact provider and ask a non-standard follow up question,"** the reviewer will contact the person or organization that billed the claim and ask them if they would like to submit an attestation statement or signature log within 20 calendar days. The 20 day timeframe begins once the contractor makes an actual phone contact with the provider or on the date the request letter is received at the post office. (Reviewers will not contact the provider if the claim should be denied for reasons unrelated to the signature requirement.)
  - In the situations where the guidelines indicate **"signature requirements NOT met,"** the reviewer will disregard the entry and make the claims review determination using only the other submitted documentation.

Electronic Prescribing

Electronic prescribing (e-prescribing) is the transmission of prescription or prescription-related information through electronic media. E-prescribing takes place between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan. It can take place directly or through an e-prescribing network. With e-prescribing, health care professionals can electronically transmit both new prescriptions and responses to renewal requests to a pharmacy without having to write or fax the prescription. E-prescribing can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care. Note the following key points:

- Reviewers will accept as a valid order any Part B drugs, other than controlled substances, ordered through a qualified E-Prescribing system. For Medicare Part B medical review purposes, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. To review the official standards for electronic prescribing, 42 CFR 423.160 Standards for Electronic Prescribing, you may go to http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr423.160.pdf on the Internet.
- When Part B drugs, other than controlled substances, have been ordered through a qualified E-Prescribing system, the

reviewer will NOT require the provider to produce hardcopy pen and ink signatures as evidence of a drug order.

- At this time, AC, MAC, CERT, PSC, and ZPIC reviewers shall NOT accept as a valid order any controlled substance drugs that are ordered through any E-Prescribing system, even one which is qualified under Medicare Part D. When reviewing claims for controlled substance drugs, the reviewer shall only accept hardcopy pen and ink signatures as evidence of a drug order.
- At this time, the AC, MAC, CERT, PSC and ZPIC reviewers shall accept as a valid order any drugs incident to DME, other than controlled substances, ordered through a qualified E-Prescribing system. For the purpose of conducting Medicare medical review of drugs incident to DME, a qualified E-Prescribing system is one that meets all 42 CFR 423.160 requirements. When drugs incident to DME have been ordered through a qualified E-Prescribing system, the reviewer shall NOT require the provider to produced hardcopy pen and ink signatures as evidence of a drug order.

Additional Information

CR 6698 includes a helpful table that summarizes the situations where signature requirements are met and/or a Medicare contractor may contact the provider to determine if the provider wishes to submit an attestation statement or signature log. Key portions of that table are as follows:

		Signature Requirement Met	Contact billing provider and ask a non-standardized follow up question
1	Legible full signature	X	
2	Legible first initial and last name	X	
3	Illegible signature over a typed or printed name	X	
4	Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signator. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names. One of the names is circled.	X	
5	Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: 1) a signature log, or 2) an attestation statement	X	
6	on letterhead and the documentation is Unaccompanied by: a) a signature log, or b) an attestation statement		X
7	Initials over a typed or printed name	X	
8	Initials NOT over a typed/printed name but accompanied by: a) a signature log, or b) an attestation statement	X	
9	Initials NOT over a typed/printed name Unaccompanied by: a) a signature log, or b) an attestation statement		X
10	Unsigned typed note with provider's typed name Example: _____ John Whigg, MD		X
11	Unsigned typed note without providers typed/printed name		X
12	Unsigned handwritten note, the only entry on the page		X
13	Unsigned handwritten note where other entries on the same page in the same handwriting are signed.	X	
14	"signature on file"		X

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

The official instruction, CR6698, issued to your Medicare FI, carrier, A/B MAC, RHHI or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R327PI.pdf on the CMS website.

Clinical Review Judgment

MLN Matters® Number: MM6954 *Revised*
Related Change Request (CR) #: 6954
Related CR Release Date: May 14, 2010
Effective Date: April 23, 2010
Related CR Transmittal #: R338PI
Implementation Date: June 15, 2010

Note: This article was revised on June 16, 2010, to include an additional reference to Chapter 3 of the Medicare Program Integrity Manual on page 2. All other information remains the same.

Provider Types Affected

This impacts all physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6954, from which this article is taken:

- Adds Section 3.14 (Clinical Review Judgment) to the Medicare Program Integrity Manual, clarifying existing language regarding clinical review judgments; and
- Requires that Medicare claim review contractors instruct their clinical review staffs to use clinical review judgment when making complex review determinations about a claim.

Background

Medicare claim review contractors (Carriers, Fiscal Intermediaries (called affiliated contractors, or ACs), Medicare Administrative Contractor (MACs), the Comprehensive Error Rate Testing (CERT) contractor, and Recovery Audit Contractors (RACs)), along with Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC) are tasked with measuring, detecting and correcting improper payments in the Fee for Service (FFS) Medicare Program.

CR 6954, from which this article is taken, updates the Medicare Program Integrity Manual by adding a new Section (3.14 -- Clinical Review Judgment) which clarifies existing language regarding clinical review judgments; and also requires that Medicare claim review contractors instruct their clinical review staffs to use the clinical review judgment process when making complex review determinations about a claim.

This clinical review judgment involves two steps:

1. The synthesis of all submitted medical record information (e.g. progress notes, diagnostic findings, medications, nursing notes, etc.) to create a longitudinal clinical picture of the patient; and
2. The application of this clinical picture to the review criteria to determine whether the clinical requirements in the relevant policy have been met.

Note: Clinical review judgment does not replace poor or inadequate medical record documentation, nor is it a process that review contractors can use to override, supersede or disregard a policy requirement (policies include laws, regulations, Centers for Medicare & Medicaid (CMS) rulings, manual instructions, policy articles, national coverage decisions, and local coverage determinations).

Additional Information

You can find more information about clinical review judgment by going to CR 6954, located at http://www.cms.gov/Transmittals/downloads/R338PI.pdf on the Centers for Medicare & Medicaid Services (CMS) website. You will find the updated Medicare Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section14 (Clinical Review Judgment) as an attachment to that CR. The original Chapter 3, which contains more information on CMS' medical review processes, is available at http://www.cms.gov/manuals/downloads/pim83c03.pdf on the CMS website.

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

Electronic Data Interchange (EDI)

Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Version 005010 Medicare Administrative Contractors Requirements

MLN Matters® Number: MM6472
Related Change Request (CR) #: 6472
Related CR Release Date: June 19, 2009
Effective Date: October 1, 2009
Related CR Transmittal #: R506OTN
Implementation Date: October 5, 2009

Provider Types Affected

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

Provider Action Needed

This article is informational only for providers. It is based on Change Request (CR) 6472 which provides Medicare Administrative Contractors (MACs), and DME MACs, and the DME MACs Common Electronic Data Interchange (CEDI) Contractor with requirements to prepare their systems to process ASC X12 (also known as ANSI ASC X12) version 005010 (both A/B and DME MACs) transactions and National Council for Prescription Drug Programs (NCPDP) version

D.0 (only DME) transactions. While CR 6472 requires no action for providers, you may want to review MLN Matters® article SE0904, at http://www.cms.gov/MLNMattersArticles/downloads/SE0904.pdf, for an introductory overview of these HIPAA standards.

Background

The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version D.0 as the next Health Insurance Portability and Accountability Act (HIPAA) transaction standards for covered entities to exchange HIPAA transactions. The DHHS published the final rule on January 16, 2009, which can be reviewed at http://edocket.access.gpo.gov/2009/pdf/E9-740.pdf on the Internet. The Centers for Medicare & Medicaid Services (CMS) is in the process of implementing this next version of HIPAA transaction standards.

The purpose of Change Request 6472 is to provide the MACs and the DME MACs Common Electronic Data Interchange (CEDI) Contractor with the necessary requirements to prepare their systems to process ASC X12 version 005010 (both A/B and DME MACs) and NCPDP version D.0 (only DME) transactions.

Note: The DHHS has promulgated in the Final Rules provisions which permit dual use of existing standards [ASC X12 4010A1 and NCPDP 5.1] and the new standards [ASC X12 version 5010 and NCPDP version D.0] from March 17, 2009 (the effective date) until January 1, 2012 (the compliance date) to facilitate testing (subject to trading partner agreement).

Additional Information

The official instruction, CR 6472, issued to your MAC or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R506OTN.pdf on the CMS website.

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

Claim Status Category Code and Claim Status Code Update

MLN Matters® Number: MM6859
Related Change Request (CR) #: 6859
Related CR Release Date: March 26, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R1936CP
Implementation Date: July 6, 2010

Provider Types Affected

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

Provider Action Needed

This article, based on CR6859, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 were updated during the January 2010 meeting of the national Code Maintenance Committee and code changes approved at that meeting were posted at http://www.wpc-edi.com/content/view/180/223/ on the Internet on or about March 1, 2010. At the January 2010 meeting, the committee also decided to allow the industry 6 months for implementation of newly added or changed codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on July 6, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementation.

Background

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

Additional Information

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

The official instruction, (CR6859), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1936CP.pdf on the CMS website.

Additional Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)

MLN Matters® Number: MM6975
Related Change Request (CR) #: 6975
Related CR Release Date: May 21, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R709OTN
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, providers and suppliers who bill

Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Regional Home Health Intermediaries (RHHI)), for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6975 to alert providers that, according to the Administrative Simplification provisions of HIPAA Regulations, the Secretary of the Department of Health and Human Services (DHHS) is required to adopt standard electronic transactions and code sets. CMS is currently in the process of implementing the next version of the HIPAA Transaction 835 standard – referred to as 835v5010 in this document. Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.

Key Points of CR6975

The Secretary of DHHS has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

- Effective Date of the regulation: March 17, 2009;
- Level I compliance by: December 31, 2010;
- Level II Compliance by: December 31, 2011; and
- All covered entities have to be fully compliant on: January 1, 2012.

Background

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

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

CMS will be fully compliant on January 1, 2012, by completing Level I compliancy by December 31, 2010, and Level II compliancy by December 31, 2011. The transition period when both versions would be allowed in production mode for Medicare will be from January 1, 2011 – December 31, 2011. The 835v4010A1 and the current Standard Paper Remittance (SPR) should not be sent on or after January 1, 2012, irrespective of the date of receipt or date of service reported on the electronic or paper claim.

Additional Information

If you have questions, please contact your Medicare Carrier, A/B MAC, FI and/or RHHI at their toll-free number which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

The official instruction associated with this CR6975, issued to your Medicare Carrier, A/B MAC, FI and/or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R709OTN.pdf on the CMS website.

Claims

Guidance on Implementing System Edits for Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

MLN Matters® Number: MM6566
Related Change Request (CR) #: 6566
Related CR Release Date: May 21, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R710OTN
Implementation Date: July 6, 2010

Note: This article was revised on May 24, 2010, to reflect changes made to CR 6566 on May 21, 2010. The CR release date, transmittal number, and the Web address for accessing CR 6566 were changed. All other information is the same.

Provider Types Affected

This article is for suppliers who submit claims to Medicare DME Medicare Administrative Contractors (DME MACs) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6566. The Centers for Medicare & Medicaid Services (CMS) is issuing CR6566 to provide further guidance to suppliers of DMEPOS regarding licensing, accreditation, or other mandatory quality requirements that may apply. DMEPOS suppliers should be aware that if they are not identified by the National Supplier Clearing House-Medicare Administrative Contractor (NSC-MAC) as being accredited to supply the specific product/service AND they are not exempt from accreditation, their claims will be automatically denied by Medicare.

Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) added a new paragraph 1834(a)(20) to the Social Security Act (the Act). This paragraph requires the Secretary of the Department of Health and Human Services to establish and implement quality standards for suppliers of DMEPOS. All suppliers that furnish such items or services set out at subparagraph 1834(a)(20)(D) as the Secretary determines appropriate must comply with the quality standards in order to receive Medicare Part B payments and to retain a Medicare supplier number to be able to bill Medicare. Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834(a)(13), Section 1834(h)(4) and Section 1842(s)(2) of the Act. The covered items include:

- DME;
- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Transfusion medicine; and
- Prosthetic devices, prosthetics, and orthotics.

Section 154(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added a new subparagraph (F) to Section 1834(a)(20) of the Act. In implementing quality standards under this paragraph the Secretary will require suppliers furnishing items and services directly, or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009 accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act);
- Physical Therapists;
- Occupational Therapists;
- Qualified Speech-Language Pathologists;
- Physician Assistants;
- Nurse Practitioners;
- Clinical Nurse Specialists;
- Certified Registered Nurse Anesthetists;
- Certified Nurse-Midwives;
- Clinical Social Workers;
- Clinical Psychologists;
- Registered Dietitians; and
- Nutritional Professionals.

Additionally, MIPPA allows that "other persons" are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, "such other persons" are specifically defined as the following practitioners:

- Orthotists;
- Prosthetists;
- Opticians; and
- Audiologists.

Key Points of CR6566

Edits for the Healthcare Common Procedure Coding System (HCPCS) codes in the product categories designated by MIPPA as requiring accreditation will be in effect. Effective for claims with dates of service on or after July 6, 2010, this Medicare systems edit will automatically deny claims for these codes unless:

1. The DMEPOS supplier has been identified as accredited for the timeframe that covers the date of service on the claim; or
2. The DMEPOS supplier is currently exempt from meeting the accreditation requirements.

Take Note: Products and services requiring accreditation found on CMS 855S, Section 2D next to the NSC-MAC product codes along with HCPCS codes are as follows:

(To review the descriptors that accompany the HCPCS codes in the product categories see Attachment C of CR6566. The Web address of CR6566 can be found in the Additional Information section of this article.)

NSC-MAC Product Code	Product Category	HCPCS codes
DM06	Blood Glucose Monitors and Supplies (mail order)	A4253, A4259, A4256, A4258, A4235, A4233, A4234, A4236
M01	Canes and Crutches	A4636
R01	Enteral Nutrients, Equipment and Supplies	B4035, B4154, B4150, B4152, B4034, B9002, B4153, B4036, B4155, B4149, B9000, B4082, B4081, B4083, B4087, B4088
DM09	Hospital Beds – Electric	E0260, E0261, E0265, E0294, E0295, E0266, E0296, E0297
DM10	Hospital Beds – Manual	E0303, E0255, E0910, E0250, E0940, E0271, E0304, E0301, E0912, E0272, E0302, E0310, E0256, E0911, E0316, E0305, E0292, E0251, E0290, E0293, E0300, E0280, E0291
R08	Oxygen Equipment and Supplies	E1390, E0431, E0439, E0434, K0738, E1392, E0424, E0443, E1391, E0442, E0441, E0443, E0444
R09	Respiratory Assist Devices	E0470, E0471, E0472
DM20	Support Surfaces: Pressure Reducing Beds/Mattresses/ Overlays/Pads	E0277, E0372, E0373, E0371, E0193
M05	Walkers	E0143, E0135, E0156, E0149, E0154, E0141, E0147, E0155, E0148, E0140, E0144, E0130, E0158, E0159, E0157, A4637
M09	Wheelchairs - Complete Rehabilitative Power Wheelchairs	K0835, K0836, K0841, K0838, K0837, K0842, K0843, K0839, K0840
M09A	Wheelchairs - Complete Rehabilitative Power Wheelchair Related Accessories	
M07	Wheelchairs - Standard Power	K0823, K0822, , K0825, K0800, K0824, K0814, K0821, K0801, K0816, K0827, K0815, K0826, K0813, K0806, K0807, K0828, K0802, K0829, K0820, K0808
M07A	Wheelchairs - Standard Power Related Accessories	

Additional Information

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

The official instruction (CR6566) issued to your Medicare DME MAC is available at http://www.cms.gov/Transmittals/downloads/R710OTN.pdf on the CMS website.

For additional information about the NSC-MAC and Recent Regulatory Revisions Pertinent to Suppliers of DMEPOS, see MLN Matters® article MM6282, which is available at http://www.cms.gov/mlnmattersarticles/downloads/MM6282.pdf on the CMS website.

Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prostheses Healthcare Common Procedure Coding System (HCPCS) Code

MLN Matters® Number: MM6743
Related Change Request (CR) #: 6743
Related CR Release Date: April 29, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R686OTN
Implementation Date: October 4, 2010

Provider Types Affected

This article is for physicians, non-physician practitioners and suppliers submitting claims to Medicare contractors (Medicare Administrative Contractors (MACs), carriers and/or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for tracheo-esophageal voice prostheses provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 6743, which changes the claims filing jurisdiction for Healthcare Common Procedure Coding System (HCPCS) code L8509. HCPCS code L8509 describes a tracheo-esophageal voice prosthesis inserted by a licensed health care provider, any type. This device is inserted in a physician's office or other outpatient setting. Effective for dates of service on or after October 1, 2010, claims for HCPCS code L8509 must be submitted to the A/B MAC or Part B carrier, as applicable, instead of the DME MAC. This jurisdictional policy does not apply to tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting (HCPCS code L8507). The filing jurisdiction for these claims remains with the DME MACs. Be sure billing staff know of this change.

Key Points of CR 6743

- Effective for dates of service on or after October 1, 2010, the DME MACs will deny claims containing HCPCS code L8509 as not payable under the contractor's claims jurisdiction area. When Medicare denies such claims, the provider will receive these messages: remark code N418 (Misrouted claim. See the payer's claim submission instructions.) and reason code 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor).
- Effective for dates of service on or after October 1, 2010, the A/B MACs and Part B carriers will accept HCPCS code L8509 for processing.
- The A/B MACs and Part B carriers will cover claims for HCPCS code L8509 as a prosthetic device. The A/B MACs and Part B carriers will base the Medicare allowed payment amount on the lower of the actual charge or the fee schedule amount for HCPCS code L8509.
- Tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting are billed using HCPCS code L8507 (tracheo-esophageal voice prostheses, patient inserted, any type, each) and are eligible for coverage under the prosthetic device benefit. The filing jurisdiction for these claims remains with the DME MACs.
- Medicare does not cover the item if it is shipped or dispensed to the beneficiary, who then takes the item to their physician's office for insertion. The A/B MACs or Part B carriers will deny claims in these instances, as described in Chapter 15, Section 120, in, the Medicare Benefit Policy Manual, which states that "Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient's condition."

Additional Information

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

The official instruction, CR6743, issued to your, A/B MAC, carrier and/or DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R686OTN.pdf on the CMS website.

Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity Exclusion. CR6880 rescinds and fully replaces CR 6544.

MLN Matters® Number: MM6880
Related Change Request (CR) #: 6880
Related CR Release Date: April 9, 2010
Effective Date: July 9, 2010
Related CR Transmittal #: R1944CP and R122BP
Implementation Date: July 9, 2010

Provider Types Affected

This article applies to physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for

services provided to Medicare beneficiaries in State or local penal custody.

What You Need to Know

This article is based on Change Request (CR) 6880 which updates billing instructions and claims processing requirements to fully implement the policy for Medicare beneficiaries in State or local custody that was outlined in CR 6544. CR 6880 rescinds and fully replaces CR 6544, and revises the Medicare Claims Processing Manual, Chapter 1, Section 10.4 and the Medicare Benefit Policy Manual, Chapter 17, Section 50.3.3(3). These revisions are included as attachments to CR 6880.

Background

The Medicare program does not pay for services if:

- The beneficiary has no legal obligation to pay for the services, and
- No other person or organization has a legal obligation to provide or pay for that service.

Also, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services. See the Social Security Act Section 1862 (a)(2)&(3) at http://www.socialsecurity.gov/OP_Home/ssact/title18/1862.htm on the Internet.

In the Fiscal Year (FY) 2008 Inpatient Prospective Payment System (IPPS) final rule (72 FR 47409 and 47410; see http://edocket.access.gpo.gov/2007/pdf/07-3820.pdf on the Internet), the Centers for Medicare & Medicaid Services (CMS) clarified its regulations at 42 CFR 411.4(b) (see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr411_main_02.tpl on the Internet) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are:

- Under arrest;
- Incarcerated;
- Imprisoned;
- Escaped from confinement;
- Under supervised release;
- On medical furlough;
- Required to reside in mental health facilities;
- Required to reside in halfway houses;
- Required to live under home detention; or
- Confined completely or partially in any way under a penal statute or rule.

42 CFR 411.4(b) describes the special conditions that must be met in order for Medicare to make payment for individuals who are in custody and states:

"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."

Note: Your Medicare contractor will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources. In addition, the State or local entity must document its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, your Medicare contractor will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the State or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

The Centers for Medicare & Medicaid Services (CMS) maintains a file of incarcerated beneficiaries, obtained from the Social Security Administration (SSA) that is used to edit claims.

To avoid improper denial of claims, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above should indicate this fact with the use of a the QJ modifier on claims for such services.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals should identify the incarceration period by billing as non-covered all days, services and charges that overlap the incarceration period.

Additional Information

The official instruction, CR 6880, was issued to your carrier, FI, A/B MAC, and DME MAC in two transmittals. The first transmittal modifies the Medicare Claims Processing Manual and it is available at http://www.cms.gov/Transmittals/downloads/R1944CP.pdf on the CMS website. The second transmittal is at http://www.cms.gov/Transmittals/downloads/R122BP.pdf and it contains the revised portion of the Medicare Benefit Policy Manual regarding this change.

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/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Updated Form CMS-1500 Information

MLN Matters® Number: MM6929
Related Change Request (CR) #: 6929
Related CR Release Date: May 21, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R1970CP
Implementation Date: October 4, 2010

Provider Types Affected

This is an informational article for physicians, providers and suppliers who use Form CMS-1500 to submit claims to Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment (DME) MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article, based on Change Request (CR) 6929, updates Form CMS-1500 information in the Medicare Claims Processing Manual by removing language allowing the use of legacy identifiers and making other technical corrections as a result of that change. As part of this update, providers are reminded that they are responsible for purchasing their own CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as the forms follow the specifications approved by the Centers for Medicare & Medicaid Services as developed by the American Medical Association. Photocopies of the Form CMS-1500 are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. You may purchase forms from the U.S. Government Printing Office by calling 1-202-512-1800.

Additional Information

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

The official instruction issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1970CP.pdf on the CMS website.

Appeals

Change in the Amount in Controversy (AIC) Requirement for Administrative Law Judge Hearings and Federal District Court Appeals

MLN Matters® Number: MM6894
Related Change Request (CR) #: 6894
Related CR Release Date: May 7, 2010
Effective Date: August 9, 2010
Related CR Transmittal #: R1965CP
Implementation Date: August 9, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6894, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2010.

- The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2010, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2010, is $130.
- For Federal District Court review, the amount remaining in controversy goes from $1,220 for requests on or after January 1, 2009, to $1,260 for requests on or after January 1, 2010.

Please ensure that your staff knows of these changes.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6894 modifies the Medicare Claims Processing Manual, Chapter 29, Sections 220, 330.1, and 345.1 to update the AIC required for an ALJ hearing or judicial court review. CR 6894 also expands the background information in the Amount in Controversy General Requirements, Principles for Determining Amount in Controversy, and Aggregation of Claims to meet Amount in Controversy sections 250, 250.1, 250.2 and 250.3 in the Claims Processing Manual, Chapter 29. The revised portions of the manual are attached to CR 6894.

Additional Information

The official instruction (CR 6894) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at http://www.cms.gov/Transmittals/downloads/R1965CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

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

A brochure entitled, The Medicare Appeals Process: Five Levels To Protect Providers, Physicians And Other Suppliers, provides an overview of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process. The brochure is available at http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsProcess.pdf on the CMS website.

Guidelines to Allow Contractors to Develop and Utilize Procedures for Accepting and Processing Appeals via Facsimile and/or via a Secure Internet Portal/Application

MLN Matters® Number: MM6958
Related Change Request (CR) #: 6958
Related CR Release Date: June 11, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R1986CP
Implementation Date: October 1, 2010

Provider Types Affected

This article is for physicians, providers, and suppliers submitting Medicare fee-for-service (FFS) claim appeal requests to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)).

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6958 which updates the current instructions in the Medicare Claims Processing Manual, Chapter 29, to allow Medicare contractors to accept claim appeal requests via facsimile and/or via a secure Internet portal/application.

CAUTION – What You Need to Know

CR 6958 provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via facsimile and/or via a secure Internet portal/application. At this time, Medicare contractors are not required to accept appeals via facsimile or via secure Internet portal/application. Medicare contractors wishing to utilize a secure Internet portal/application must seek approval from the Centers for Medicare & Medicaid Services (CMS) prior to implementation of that portal/application.

GO – What You Need to Do

Note that, even if your contractor allows submission of appeal requests via facsimile and/or via a secure Internet portal/application, the decision to use those venues is yours. Your contractor may not require you to use those venues. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Several Medicare contractors have requested authority from the CMS to utilize a secure Internet portal/application to receive and process Medicare FFS claim appeal requests. In addition, several Medicare contractors have begun to accept claim appeal requests received in writing via facsimile.

CR 6958 provides guidance regarding appeal requests received in writing via facsimile or via a secure Internet portal/application, and it provides guidance to Medicare contractors who have already modified or currently wish to modify their procedures to allow for receipt and/or processing of redetermination requests via these mechanisms.

The purpose of CR 6958 is to update the current instructions in the Medicare Claims Processing Manual, Chapter 29 (Appeals of Claims Decisions), to allow Medicare contractors to accept appeal requests via facsimile and/or via a secure Internet portal/application.

CMS does not require its contractors to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application is at the discretion of the appellant. Contractors will continue to accept appeal requests in hard copy via mail. Key portions of CR 6958 for providers are as follows:

What Constitutes a Request for Redetermination

Written Requests for Redetermination Submitted by a State, Provider, Physician or Other Supplier

States, providers, physicians, or other suppliers with appeal rights must submit written requests via mail, facsimile (if the contractor chooses to receive requests via facsimile), or, where available, secure Internet portal/application indicating what they are appealing and why. The acceptable written ways of doing this are via:

- A completed Form CMS-20027 (constitutes a request for redetermination). The contractor supplies these forms upon request by an appellant. "Completed" means that all applicable spaces are filled out and all necessary attachments are included with the request.
- A written request not on Form CMS-20027. At a minimum, the request shall contain the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- The specific service(s) and/or item(s) for which the redetermination is being requested;
- The specific date(s) of the service; and
- The name and signature of the party or the representative of the party.

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either: (1) explicitly asks the contractor to take further action, or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination.

- A secure Internet portal/application. If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall include the required elements for a valid appeal request as outlined under Chapter 29, Section 310.1.B.2.b which is attached to CR 6958.

Note: Some redetermination requests may contain attachments. For example, if the Remittance Advice (RA) is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Requirements for a Valid Signature on an Appeal Request:

For appeal purposes, the only acceptable method of documenting the appellant's signature on the appeal request is by written, digital, digitized, or electronic signature as discussed below:

- A written signature may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- An electronic, digital, and/or digitized signature is an acceptable signature on a request submitted via a CMS-approved secure Internet portal/application. The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, "electronically signed by" or "verified/approved by" etc.
- A stamp signature or other indication that a "signature is on file" on the CMS 20027 form or other documentation (such as a blank claim form) submitted to support the appeal request shall not be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail or via facsimile.

How Contractors will Handle Multiple Requests for Redetermination for the Same Item/Service:

If a contractor receives multiple timely requests for redetermination for the same item or service from either multiple parties or via multiple venues (i.e., hard copy mail, facsimile, or via a secure Internet portal/application) the contractor acts as follows:

- If a decision or dismissal notice has already been issued or the claim for the item/service at issue has been adjusted/paid in accordance with the redetermination decision and the contractor receives additional redetermination request(s) for the same items/services, the contractors will treat the additional request as an inquiry. Contractors shall not issue a dismissal notice.

Note: In accordance with the Medicare Claims Processing Manual (Chapter 29, Section 310.6.3 which is attached to CR6958), if an appellant requests that the contractor vacates its dismissal action and the contractor determines that it cannot vacate the dismissal; it sends a letter notifying the appellant accordingly. The contractor shall not issue a second dismissal notice to the appellant since a dismissal should only be issued in response to an appeal request.

- If a decision or dismissal notice has not been issued (i.e., the appeal is pending), and the claim for the items/services at issue has not been otherwise adjusted/paid following the redetermination decision, then upon receipt of additional redetermination request(s) for the same items/services, the contractor shall:
  1. Combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with the requirements as outlined in 42 CFR 405.944(c). See http://edocket.access.gpo.gov/cfr_2009/octqtr/pdf/42cfr405.944.pdf on the Internet.
  2. When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that multiple requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized) so that it is clear to the appellant that the decision or dismissal was issued timely in accordance with 42 CFR 405.944(c).
- If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting multiple requests for redetermination via multiple venues, the contractor shall take additional steps to educate the appellant regarding the appeals process.

Timely Processing Requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of the Medicare Claims Processing Manual, Chapter 29, Section 310.4(D)(4), which is attached to CR 6958). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties. Affirmations processed via a CMS approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application.

2. For partial reversals and full reversals, when all of the following actions have been completed:
   - The decision letter, if applicable, is mailed to the parties (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application), and
   - The actions to initiate the adjustment action in the claims processing system are taken.
3. For withdrawals and dismissals, the date that the dismissal notice is mailed (or if processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application) to the parties.

The Redetermination Decision

The law requires contractors to conclude and mail and/or otherwise transmit, as noted below, the redetermination within 60 days of receipt of the appellant's request, as indicated in the Medicare Claims Processing Manual, Chapter 29, Section 310.4, which is attached to CR 6958. For unfavorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and appointed representative, if applicable).

Contractors shall provide the decision, as required below; in writing via hard copy mail (unless the contractor has submitted a request and received approval for use of secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically). Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism.

Requirements for Use of Secure Internet Portal/Application to Support Appeals Activities

Contractors who develop and utilize a secure Internet portal/application for appeals purposes will ensure, at a minimum:

- CMS approves the proposed portal/application and usage prior to development and implementation.
- Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request (the system must include verbiage instructing the appellant not to submit additional redetermination requests for the same item/service via a different venue).
- The secure Internet portal/application includes a formal registration process that validates the signature and requires, at a minimum, use of restricted user IDs and passwords.
- Templates for submission of electronic appeal requests must include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- Contractors utilizing an approved portal/application must provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.
- Contractors must also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.
- Contractors utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.
- Redetermination decision and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements. In addition, contractors shall provide hard copy decision and/or dismissal notices to parties to the appeal and who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).
- Contractors will also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of

the notification is tracked/marked both in the system and on any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.

Additional Information

DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1986CP.pdf on the CMS website.

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

PECOS

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)

MLN Matters Number: MM6421 *Revised*
Related Change Request (CR) #: 6421
Related CR Release Date: February 26, 2010
Effective Dates: Phase 1 – October 1, 2009
Phase 2 – January 1, 2011
Related CR Transmittal #: R643OTN
Implementation Date: Phase 1 – October 5, 2009
Phase 2 – January 3, 2011

Note: This article was revised on March 30, 2010, to reflect the changes in the release of a new CR on February 26, 2010. The implementation date and effective dates of Phase 2 are changed (see page 3, third bullet). The Transmittal number, CR release date and Web address for accessing the CR has also been changed. All other information remains the same.

However, it is extremely important to read MLN Matters® Special Edition article, SE1011, at http://www.cms.gov/MLNMattersArticles/downloads/SE1011.pdf to see important clarifying information regarding this issue.

Provider Types Affected

Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for items or services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on change request (CR) 6421, which requires Medicare implementation of system edits to assure that DMEPOS suppliers bill for items or services only when those items or services are ordered or referred by physician and non-physician practitioners who are eligible to order/refer such services. Physician and non-physician practitioners must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and of the type/specialty eligible to order/refer services for Medicare beneficiaries. Be sure billing staff are aware of these changes that will impact DMEPOS claims received and processed on or after October 5, 2009.

Background

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

The providers who can order/refer are:

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

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS with one of the above specialties.

Key Points

- **During Phase 1 (October 5, 2009- January 2, 2011):** If the ordering/referring provider is not on the claim, the claim will not be paid.If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer in Medicare. If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will continue to process.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.

- **During Phase 2, (January 3, 2011 and thereafter):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.
- In both phases, Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.
- When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.
- Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at https://pecos.cms.hhs.gov/pecos/login.do on the CMS website. Before using Internet-based PECOS, providers should read the educational material about Internet-based PECOS that is available at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website. Once at that site, scroll to the downloads section of that page and click on the materials that apply to you and your practice.

Additional Information

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

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R643OTN.pdf on the CMS website.

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

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

Provider Types Affected

Physicians, non-physician practitioners (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, Part B providers and suppliers who submit claims to carriers, Part B Medicare Administrative Contractors (MACs), 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 an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS), 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-855I). If you reassign your Medicare benefits to a group or clinic, you will also need to complete the CMS-855R.

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: Beginning January 3, 2011, Medicare will reject Part B 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 records in PECOS and must be of a specialty that is eligible to order and refer.

Enrolled physicians and non-physician practitioners who do not have enrollment records in PECOS and who submit enrollment applications in order to get their enrollment information into PECOS should not experience any disruption in Medicare payments, as a result of submitting enrollment applications.

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, which is January 3, 2011.

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 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;
  - Claims from suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for ordered DMEPOS; and
  - Claims from specialists or specialty groups for referred services.
- 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, doctor of chiropractic medicine),
  - Physician Assistant,
  - Certified Clinical Nurse Specialist,
  - Nurse Practitioner,
  - Clinical Psychologist,
  - Certified Nurse Midwife, and
  - Clinical Social Worker.

Questions and Answers Relating to the Edits

1. **What will the edits do?**
   The edits will determine if the Ordering/Referring Provider (when required to be identified in a Part B claim) (1) has a current Medicare enrollment record (i.e., the enrollment record is in PECOS and it contains the National Provider Identifier (NPI)), and (2) is of a 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 began on October 5, 2009, and is scheduled to end on January 2, 2011. In Phase 1, if the Ordering/Referring Provider does not pass the edits, the claim will be processed and paid (assuming there are no other problems with the claim) but the Billing Provider (the provider who furnished the item or service that was ordered or referred) will receive an informational message* from Medicare in the Remittance Advice†.

     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.

     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 is scheduled to begin on January 3, 2011, and will continue thereafter. In Phase 2, if the Ordering/Referring Provider does not pass the edits, the claim will be rejected. This means that the Billing Provider will not be paid for the items or services that were furnished based on the order or referral.

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.‡

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 periodic 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/MedicareProviderSupEnroll; click on "Ordering Referring Report" (on the left). Information about the Report will be displayed.

* The informational messages vary depending on the claims processing system.

† DMEPOS suppliers who submit paper claims will not receive an informational message on the Remittance Advice.

‡ NPIs were added only when the matching criteria verified the NPI.

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 (that is, your enrollment record is in PECOS and it includes your NPI).**
   - ✓ If you enrolled in Medicare after 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - ✓ If you enrolled in Medicare prior to 2003 but submitted an update(s) to your enrollment information since 2003, your enrollment record is in PECOS and CMS may have added your NPI to it.
   - ✓ If you enrolled in Medicare prior to 2003 and have not submitted an update to your Medicare enrollment information in 6 or more years, you do not have an enrollment record in PECOS. You need to take action to establish one. See the last bullet in this section.
   - ✓ If you are not sure, 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 (that is, your enrollment record is in PECOS and it contains your NPI); (2) contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS that contains the NPI; or (3) use Internet-based PECOS to look for your PECOS enrollment record (if no record is displayed, you do not

have an enrollment record in PECOS). 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 PECOS:**

- 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 print, sign, and date the Certification Statement and mail the 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/MedicareProviderSupEnroll, 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.

Note: For physicians/non-physician practitioners who reassign all their Medicare benefits to a group/clinic: If you reassign all of your Medicare benefits to a group/clinic, the group/clinic must have an enrollment record in PECOS in order for you to enroll via the web. You should check with the officials of the group/clinic or with your designated Medicare enrollment contractor if you are not sure if the group/clinic has an enrollment record in PECOS. If the group/clinic does not have an enrollment record in PECOS, you will not be able to use the web to submit your enrollment application to Medicare. You will need to submit a paper application, as described in the bullet below.

b. Obtain a paper enrollment application (CMS-855I), 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 reassign all your Medicare benefits to a group/clinic, you will also need to fill out, sign and date the CMS-855R, obtain the signature/date signed of the group's Authorized Official, and mail the CMS-855R, along with the CMS-855I, to the designated Medicare enrollment contractor. Enrollment applications are available for downloading from the CMS forms page (http://www.cms.gov/cmsforms) or by contacting your designated Medicare enrollment contractor.

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). Opt-out practitioners whose affidavits are current should have enrollment records in PECOS that contain their NPIs.

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 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 two 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 enrollment records in PECOS 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 about once a month to ensure it is as current as practicable. 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 resubmit 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 (e.g., Bob Jones instead of Robert Jones will cause the claim to fail the edit, as the edit will look for R, not B, as the first letter of the first name). 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 rejected because they failed the Ordering/Referring Provider edits are not denials of payment by Medicare that would expose the Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate.

Additional Guidance

1. **Orders or referrals by interns or residents.** Interns are not eligible to enroll in Medicare because they do not have medical licenses. Unless a resident (with a medical license) has an enrollment record in PECOS, he/she may not be identified in a Medicare claim as the Ordering/Referring Provider. The teaching, admitting, or supervising physician is considered the Ordering/Referring Provider when interns and residents order and refer, and that physician's name and NPI would be reported on the claim as the Ordering/Referring Provider.
2. **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-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.
3. **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-855I or they may use Internet-based PECOS. They must include a covering note with the paper application or with the paper Certification Statement that is generated when submitting a web-based application that states that they are enrolling in Medicare only to order and refer. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

Additional Information

You may want to review the following related CRs:

- CR 6417 at http://www.cms.gov/Transmittals/downloads/R642OTN.pdf on the CMS website;
- CR 6421 at http://www.cms.gov/Transmittals/downloads/R643OTN.pdf on the CMS website; and
- CR 6696 at http://www.cms.gov/Transmittals/downloads/R328PI.pdf on the CMS website.

If you have questions, please contact your Medicare carrier, Part A/B Medicare Administrative Contractor (A/B MAC), or durable medical equipment Medicare Administrative Contractor (DME/MAC), at their toll-free numbers, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Miscellaneous

Update to the Healthcare Common Procedure Coding System (HCPCS) Codes for Payment of Surgical Dressings in Indian Health Service (IHS) Providers

MLN Matters® Number: MM6909
Related Change Request (CR) #: 6909
Related CR Release Date: April 28, 2010
Effective Date: January 1, 2009
Related CR Transmittal #: R1957CP
Implementation Date: October 4, 2010

Provider Types Affected

This article is for all IHS and tribally owned and operated hospitals or hospital-based facilities including Critical Access Hospitals (CAHs) who bill Medicare for providing surgical dressings to Medicare beneficiaries.

What You Need to Know

CR 6909, from which this article is taken, provides no policy changes. It updates the list of surgical dressing Healthcare Common Procedure Coding System (HCPCS) codes that Indian Health Service (IHS) providers can bill to the specialty contractor (Trailblazer Health Enterprises, LLC). You should make sure that your billing staffs are aware of this update.

Background

Section 630 of the Medicare Modernization Act (MMA) of 2003 allows IHS providers to bill for other Medicare Part B services (not covered under section 1848 of the Social Security Act) for the 5 year period beginning January 1, 2005. These covered services, which include surgical dressings, are payable based on the lesser of the actual charges or the Durable Medical Equipment, Prosthetics. Orthotics and Supplies (DMEPOS) fee schedule amount. Section 2902 of the Patient Protection and Affordable Care Act indefinitely extends Section 630 of the MMA retroactive to January 1, 2010.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the list of surgical dressing HCPCS codes that IHS providers

can bill to the specialty contractor (Trailblazer Health Enterprises, LLC); and CR 6909, from which this article is taken, provides this update for calendar year 2009.

Note: IHS owned and operated providers, tribally owned and operated providers electing to bill as IHS, tribally operated IHS providers, and tribally owned and IHS operated providers are all referred to as IHS providers throughout this article. The term provider refers to all hospital or hospital-based facilities, including CAH's and outpatient clinics.

Note: IHS owned and operated providers, tribally owned and operated providers electing to bill as IHS, tribally operated IHS providers, and tribally owned and IHS operated providers are all referred to as IHS providers throughout this article. The term provider refers to all hospital or hospital-based facilities, including CAH's and outpatient clinics.

Effective January 1, 2009 through December 31, 2009, IHS providers can bill Trailblazer Health Enterprises, LLC for surgical dressings (including splints and casts) under revenue code 0623 (surgical dressings) on type of bill (TOB) 12X (hospital inpatient part B), 13X (hospital outpatient), or 85X (CAH) for the surgical dressings HCPCS codes payable under MMA 630 listed in the following table:

Surgical Dressing HCPCS Codes Payable to IHS Providers under MMA Section 630 for Calendar Year 2009			
A6010 – A6011,	A6207	A6229	A6266
A6021 –A6024,	A6209 – A6212	A6231 – A6238	A6402 –A6403,
A6154,	A6214	A6240 – A6248	A6407
A6196 –A6197,	A6219- A6220	A6251 – A6255	A6410
A6199,	A6222 – A6224	A6257 - A6259	A6441 – A6457
A6203 – A6204			

In addition, Medicare will pay claim lines on TOBs 12X, 13X, and 85X by IHS providers with dates of service on or after January 1, 2010, through December 31, 2010, and revenue code 0623 for any of the HCPCS listed in the above table. In addition, HCPCS code A6412 is added to this list for dates of service in 2010.

You should be aware that Trailblazer Health Enterprises, LLC will not search for, and adjust, claims that have been processed prior to the implementation date; but will adjust claims that you bring to their attention.

Additional Information

You can find the official instruction issued to Trailblazer Health Enterprises, LLC, CR 6909, at http://www.cms.gov/Transmittals/downloads/R1957CP.pdf on the CMS website.

Detailed information on the HCPCS mentioned in this article, as well as other HCPCS, is available at http://www.cms.gov/HCPCSReleaseCodeSets/ on the CMS website.

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

Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

MLN Matters® Number: MM6960
Related Change Request (CR) #: 6960
Related CR Release Date: May 7, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R697OTN
Implementation Date: October 4, 2010

Provider Types Affected

This issue impacts all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the timely filing limits for submitting claims for Medicare Fee-for-Service (FFS) reimbursement. As a result of the PPACA, claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare. Further details follow in this article. Make sure your billing staff is aware of these changes.

Background

Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act as well as the Code of Federal Regulations (CFR), 42 CFR Section 424.44 specify the timely filing limits for submitting claims for Medicare Fee-For-Service (FFS) reimbursement. Prior to PPACA, the regulations stated the service provider or supplier must submit claims for services furnished during the first nine (9) months of the calendar year on or before December 31st of the following calendar year. For services rendered during the last quarter of the calendar year, the provider or supplier must submit the claim on or before December 31st of the second following year.

Section 6404 of PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.

What You Need to Know

Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-PPACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline and;
- Claims with dates of service January 1, 2010 and later received more than 1 calendar year beyond the date of service will be denied as being past the timely filing deadline.

Note: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify exceptions to the one (1) calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR section 424.44(b)(1), for "error or misrepresentation" of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

Additional Information

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

The official instruction (CR6960) issued to your Medicare FI, Carrier, DME MAC, A/B MAC and/or RHHI is available at http://www.cms.gov/Transmittals/downloads/R697OTN.pdf on the CMS website.

Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC) or from one Durable Medical Equipment (DME) MAC to another DME MAC

MLN Matters® Number: SE0837
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, SE0837, has been updated and re-issued as SE1017. You can find the updated article at http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf on the Centers for Medicare & Medicaid Services website.

Section 2902 of the Patient Protection and Affordable Care Act Permanently Extends Section 630 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 for the Payment of Indian Health Services (IHS)

MLN Matters® Number: SE0930 *Revised*
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 1, 2010
Related CR Transmittal #: N/A
Implementation Date: As soon as possible

Note: This article was revised and re-issued on March 31, 2010, to reflect the impact of the Patient Protection and Affordable Care Act on these IHS services. In essence, the new Act permanently extends Section 630 of the MMA retroactive to January 1, 2010. See the rest of this article to see how the new law impacts your claims.

Provider Types Affected

Indian Health Service (IHS) tribe and tribal organizations and facilities submitting claims to Medicare contractors

Provider Action Needed

This special edition article was initially issued by the Centers for Medicare & Medicaid Services (CMS) to notify affected IHS physicians, IHS providers, and IHS suppliers that, per the provisions of section 630 of the MMA, certain Part B services were no longer covered for Medicare payment when the provisions sunset as of December 31, 2009.

However, on March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. Section 2902 of the new law permanently extends Section 630 of the MMA, retroactive to January 1, 2010.

The services involved include the following:

- Durable Medical Equipment, prosthetics, and orthotics;
- Therapeutic shoes;
- Clinical laboratory services;
- Surgical dressings, splints and casts;
- Drugs (those processed by the J4 A/B Medicare Administrative Contractor (MAC) and the DME MACs);
- Ambulance services;
- Influenza and pneumonia vaccinations; and
- Screening and preventive services.

Indian Health Service providers, suppliers, physicians and other practitioners should contact their Medicare Contractor for further guidance regarding IHS claims affected by the new law, for dates of service January 1, 2010, and after, that were denied, prior to implementation of the new law.

Note: It will take approximately two weeks for your Medicare Contractor to update their systems to be able to pay correctly for these services. You may want to wait until the claims processing system is updated before submitting any new claims containing these IHS services. CMS is committed to maintaining open lines of communication with all affected providers and stakeholders on this issue.

Please be on the alert for more information pertaining to the Patient Protection and Affordable Care Act.

Preparing for a Transition from an FI/Carrier to a Medicare Administrative Contractor (MAC) or from one Durable Medical Equipment (DME) MAC to another DME MAC

MLN Matters® Number: SE1017
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 initially issued as SE0837 in 2008. It is being re-issued as SE1017 in order to update the content to reflect current experiences with transitions to a MAC.

Provider Types Affected

All fee-for-service physicians, providers, and suppliers who submit claims to Fiscal Intermediaries (FIs), Carriers, Regional Home Health Intermediaries (RHHIs), or DME MACs for services provided to Medicare beneficiaries. **Providers already billing Medicare Administrative Contractors (MACs) have already transitioned and need not review this article. However, suppliers billing DME MACs may find the article of value as the Centers for Medicare & Medicaid Services (CMS) recompetes the DME MAC contracts, which could cause a transition from an incumbent DME MAC to a new DME MAC.**

Impact on Providers

This article is intended to assist all providers that will be affected by Medicare Administrative Contractor (MAC) implementations (or DME MAC transitions due to recompeting the DME MAC Contracts). CMS is providing this information to make you aware of what to expect as your FI or carrier transitions its work to a MAC (or your DME MAC to another DME MAC). Knowing what to expect and preparing as outlined in this article will minimize disruption in your Medicare business. Please note that other Medicare contractors servicing your region will be unaffected by this change, such as the Qualified Independent Contractor (QIC for reconsiderations), Recovery Audit Contractor (RAC), the Program Safeguard Contractor (PSC), and the Zone Program Integrity Contractor (ZPIC).

Note to DME Suppliers: The remainder of this article focuses on transitions from carriers or FIs to MACs, but suppliers note the information may also pertain to your business if there is a transition from your DME MAC to another DME MAC as those contracts are recompeted.

Background

Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B Fee-For-Service (FFS) programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new MAC authority. Medicare Contracting Reform requires that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by FIs and carriers in administering the Medicare FFS program.

When completed, there will be 15 new MACs processing Part A and Part B claims. Each MAC services a distinct set of contiguous states, also known as a "jurisdiction". Each MAC will handle different volumes of work based upon the geographic breakout of the 15 MACs. Because of this, the MACs will vary in geographic size and the amount of work they handle. Having 15 MACs should result in greater consistency in the interpretation of Medicare policies, which is a key goal of Medicare Contracting Reform.

MAC Implementation Milestones/Definitions

There are specific milestones in the cutover from carrier or FI work to MAC. In this article, providers are advised to be aware of, and to take specific action relative to the milestones defined below:

Award – This is the point at which a MAC is announced as having won the contract for specific FI or carrier work.

Cutover – This is the date on which the carrier or FI work ceases and MAC work begins. Cutover is often done in phases by State-level jurisdictions. Because of the amount of activity involved in a cutover, there may be interrupted services for a day or two.

Outgoing Contractor - A Medicare carrier or FI whose Title XVIII contract is non-renewed as a result of Medicare Contracting Reform and whose work will transition to a MAC.

Incoming MAC - The entity that has won a contract under Medicare Contracting Reform and which will assume the workload that was performed by a carrier or FI.

Pre - Award

If you are in a jurisdiction where a new MAC has not yet been awarded, you can remain current with updates on Medicare Contracting Reform by visiting http://www.cms.gov/medicarecontractingreform/ on the CMS website.

Post- Award

Once the award to the MAC is made, you should immediately begin to prepare for the cutover. The following are recommendations to help you in this effort:

Pay attention to the mail you receive from your outgoing Medicare contractor and your new MAC--you will be receiving letters and listserv messages about the cutover from both. These letters should include discussions on what, if any, impact the cutover will have on your payment schedule, issuance of checks, impact on paper and electronic claims processing, electronic funds transfers, appeals,

customer service, etc. Focus on necessary actions you must take and the critical due dates assigned, to avoid any disruptions in claims payment.

Sign up for your new MAC's listserv or if you aren't signed up for your current FI or carrier's listserv, please do so immediately. While in many cases the list of providers that were in the jurisdiction of the outgoing Medicare contractor will be shared with the incoming MAC, that may not always be the case. Subscribing to the MAC listserv distribution will ensure that you receive news and resource tools as they become available concerning the implementation.

Access and bookmark the MAC's website, particularly any part of the site devoted to information about the MAC transition/ implementation) and visit it regularly. The MAC may have a new website that will have general information, news and updates, information on the MAC's requirements of providers, copies of newsletters and information on meetings and conference calls that are being conducted by the MAC.

Review the Frequently Asked Questions (FAQs) on the MAC's website.

Participate in the MAC's advisory groups and "Ask the Contractor" teleconferences. (Note that these advisory groups are usually limited in size.) Every MAC will be conducting conference calls to give providers the opportunity to ask questions and have open discussion. Take advantage of the opportunity to communicate with the new MAC!

Review the MAC's Local Coverage Determinations (LCDs) as they may be different from the outgoing contractor's LCDs. The MAC must provide education on LCDs. Providers should monitor MAC communications and website for information regarding potential changes to the LCDs.

Two-Three Months Prior to Cutover

- **Complete and return your Electronic Funds Transfer (EFT) agreements.** CMS requires that each provider currently enrolled for EFT complete a new CMS-588 for the new MAC **and, if you are not on EFT, this may be a good opportunity to consider enrollment in EFT.** (If your new MAC is the same entity as your current FI/carrier, then a new EFT agreement is not needed.) This form is a legal agreement between you and the MAC that allows funds to be deposited into your bank account. It is critical for the MAC to receive these forms before any payments are issued. Complete the CMS-588 and submit it to the MAC to ensure that there is no delay or disruption in payment. We encourage you to do this no later than 60 days prior to cutover. If you fail to submit the CMS-588 form as required, the new MAC will place you in a "Do Not Forward" (DNF) status as required by Chapter 1, Section 80.5 of the Medicare Claims Processing Manual. Contact your MAC with any questions concerning the agreement.

  The CMS-588 form can be found at http://www.cms.gov/cmsforms/downloads/CMS588.pdf on the CMS website.

  You are encouraged to submit the agreements no later than 60 days prior to the planned cutovers. To do so, you will need to note the mailing address for the form, which is available on the MAC's website. Your current contractor may also provide instructions on its website on accurately completing the form.

- Your new MAC may also request you to execute a new **Electronic Data Interchange (EDI) Trading Partner Agreement** as well. If so, be sure to complete that agreement timely. Some helpful information on such agreements is available at http://www.cms.gov/EducationMaterials/downloads/TradingPartner-8.pdf on the CMS website.
- Some (not all) MAC contractors may assign you a new EDI submitter/receiver and logon IDs as the cutover date approaches. Review your mailings from the MAC and/or their website for information about assignment of new IDs and whether you have to do anything to get those IDs. The MAC EDI staff will send these submitter IDs and passwords to you in hardcopy or electronically. **You don't need to do anything to get the new IDs;** however, if you do receive a new ID and password, CMS strongly suggests that you contact the incoming MAC to test these IDs. Since there may be a different EDI platform, it is critical to consider testing to minimize any disruption to your business at cutover.
- **Contact your claims processing vendor, billing department, and clearinghouse** to ensure that they are aware of all changes affecting their ability to process claims with the new MAC. Ask your vendor, "Are you using the new contractor number or ID of the new MAC, submitter number and logon ID?"; "Have you tested with the MAC?"
- Because the contractor number is changing, your EDI submissions need to reflect the new MAC number at cutover.
- Be aware of the last date you can receive and download electronic remittance advices (ERAs) from your outgoing contractor.
- Be aware that some MACs may offer participation in an "early boarding" process for electronic claims submission and/or Electronic Remittance Advice (ERA). This will enable submitters the ability to convert to the new MAC prior to cutover. If you are currently receiving ERAs, you will continue to do so after cutover. As mentioned previously, some MACs may assign a new submitter/receiver ID and password –watch for and document them for use after cutover to the MAC.

Cutover Weekend

Be aware that in certain situations, CMS will have the outgoing Medicare contractor release claims payments a few days early in preparation for implementation weekend (weekend prior to cutover). Providers will be notified prior to the cutover date if they will receive such payments. While the net payments are the same, providers will experience increased total payments followed by no payments for a two week period.

Be aware that providers may also experience system **"dark days"** around cutover weekends. Providers will be notified by the MAC or outgoing contractor if a dark day(s) is planned for the MAC implementation. During a dark day, the Part A provider will

have limited EDI processing and no access to Fiscal Intermediary Standard System (FISS) to conduct claim entry or claim correction, verify beneficiary eligibility and claim status. Those providers who currently bill carriers may also experience some limited access to certain functions, such as beneficiary eligibility and claims status on dark days.

Be aware that some Interactive Voice Response (IVR) functionality may also be unavailable during a dark day.

Post-Cutover

- The first 1-2 weeks may be extremely busy at the MAC. The outgoing Medicare contractor will have the "in-process" work delivered to the new MAC shortly after cutover. It takes a week in most cases to get that workload into the system and distributed to staff.
- The new MAC will likely have new mailing addresses and telephone numbers or will transition the outgoing contractor toll-free number for use.
- Be prepared that you may experience longer than normal wait times for Customer Service Representatives (CSRs) and lengthier calls the first few weeks after implementation. The telephone lines are always very busy immediately following cutover. The MAC's staff will carefully research and respond to new callers to be certain that there are no cutover issues that have not been discovered.
- **Learn how to use the MAC's IVR.** The MAC IVR software and options may be different from the outgoing FI or carrier. A new IVR can take time to learn. Most calls are currently handled by IVR. If users are unfamiliar and resort to calling the Customer Service Representative (CSR) line, the result is a spike in volume of calls to CSRs that are difficult to accommodate.
- Check the MAC's outreach and education event schedule on the MAC's and outgoing contractor's websites. It is recommended that you have staff attend some of the education courses that may be offered by the MAC.
- Be aware that there may be changes in faxing policies (e.g., for medical records).
- Be aware that there will be changes to PO Boxes and addresses for the submission of requests for Redeterminations (appeals), inquiries, and written reopening requests.
- Be aware that the MAC may edit claims differently from your outgoing contractor, so it is important to review your Remittance Advices (RAs) carefully to identify when this occurs.
- Be aware that you may experience changes in RA coding. While the combination of codes used on the RA is often directed by CMS, there may be payment situations where the codes used on the RA are at the discretion of the contractor. In addition, some contractors may have their own informational codes that they use on paper RA for some payment situations.

CMS Post-Cutover Monitoring

Post-cutover is the CMS-designated period of time beginning with the MAC's operational date. During the post-cutover period, CMS will monitor the MAC's operations and performance closely to ensure the timely and correct processing of the workload that was transferred. The post-cutover period is generally three months, but it may vary in length depending on the progress of the implementation.

Additional Assistance

There are three attachments at the end of this article to assist you in keeping informed of the progress of the cutover as well as documenting important information:

- Attachment A is a summary of what you need to do and information you will need;
- Attachment B may be used to track communications offered by the MAC, such as training classes and conferences, and your staff participation; and
- Attachment C may be used to assist you in tracking major MAC milestones.

Additional Information

The following MLN Matters article provides additional information about the MAC implementation process:

- **MM5979:** " Assignment of Providers to Medicare Administrative Contractors" located at http://www.cms.gov/MLNMattersArticles/downloads/mm5979.pdf on the CMS website.
- **MM6207:** "Initial Enrollment Assignment for Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs)", located at http://www.cms.gov/MLNMattersArticles/downloads/MM6207.pdf on the CMS website.

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

Attachment A
TIMELINE AND CHECKLIST FOR PREPARING FOR MAC IMPLEMENTATION

Scheduled Award Date:	MAC Cutover Date:
Actual Award Date:	MAC Scheduled Dark Days
MAC Contractor:	MAC Website:
MAC Contractor Number:	MAC Contact Center Number: 1-800-
MAC Mailing Address:	MAC EDI Mailing Address:

90 Days Before Cutover

1. Visit MAC website and bookmark for future use.
2. Join the MAC Listserv.
3. Monitor:
- LCDs published by the new MAC; compare current LCDs that affect your practice's services.

4. Review:
- Provider enrollment status for all providers, update as needed.
- Pay-to address information for practice/providers, update as needed.

5. Contact:
- Your Practice Management/Billing software vendor to determine if your system will be able to send & receive data to/from the new MAC.
- Your claims clearinghouse (if used) to confirm they are or will be able to send and receive data to/from the new MAC.
- Your billing department, vendor, or clearinghouse to be sure they are aware of the changes communicated from the incoming and outgoing contractors. To avoid delays in claims submission and processing and appeals requests submission, effective dates must be communicated to your appropriate provider staff and resources.

75 Days Before Cutover

1. Check the MAC's website and/or Listserv for outreach programs, educational and informational events, FAQs, and conference calls.
2. Check your state's Medical Society or local provider organization website for MAC transition information, MAC Coordinators.

60 Days Before Cutover

1. Submit CMS Form 588 – EFT form(s) to the new MAC, if needed.
2. Register for Electronic Remittance Advice (ERA) enrollment, if you are not already enrolled.
3. Download or request a sample Remittance Advice (RA). RA codes are standard but use of codes may vary across contractors.
4. Submit test electronic claims as soon as new MAC indicates this is possible.

45 Days Before Cutover

1. Monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. Begin staff training on the MAC transition, covering locations, LCDs, telephone and fax numbers and other changes.
3. Verify readiness of software vendor, clearinghouse(s) and other trading partners.

30 Days Before Cutover

1. Continue to monitor current carrier/FI claim submissions and follow-up any open or unanswered claims that are more than 30 days past submission date.
2. New EDI Submitter ID number and password should be received.
3. New ERA enrollment confirmation should be received.
4. Submit test electronic claims if you have not done so by now.
5. Address and resolve any electronic claim issues within 10 business days.
6. Begin daily monitoring of the MAC website and e-mail from the MAC Listserv.

15 Days Before Cutover

1. Continue to monitor current carrier/FI claim submissions.
2. Verify EDI and ERA connections are operational in the new environment.
3. Collect and record all MAC telephone and fax numbers for: General Inquiry Customer Service, Provider Enrollment, Provider Relations, EDI and ERA.
4. Become familiar with the MAC IVR query system by taking advantage of educational opportunities as most IVRs are not available until cutover because new outgoing claims/NPI information has not been loaded for accessibility.
5. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.

10 Days Before Cutover

1. Address any existing open items.
2. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.

5-10 Days After Cutover

1. Begin submitting claims to the new MAC.
2. Continue daily monitoring of e-mail from the MAC Listserv and the MAC website.
3. Monitor and follow up on the MAC Open Item list.

30 Days After Cutover

1. Electronic payments should be arriving by now.
2. Payments for paper claims may be arriving by now.

Attachment B		
SCHEDULE OF MAC CONTRACTOR TRAINING CLASSES		
Scheduled Date	**Title of Class**	**Attendee**

SCHEDULE OF MAC CONFERENCES		
Scheduled Date	**Conference Subject**	**Attendee**

Attachment C Important MAC Implementation Dates	
MAC Dark Days	
Cutoff Date for Claims Submission to the Outgoing Contractor	
Last Date Outgoing Contractor Will Make Payment	
Last Date Outgoing Contractor Will Have Telephone/Customer Service	
Last Date Outgoing Contractor Will Send File to Bank	
Last Date to Retrieve ERAs from Outgoing Contractor	
Date MAC Will Accept Electronic Claims	
Date MAC Will Accept Paper Claims	
Date MAC Bill/Claim Cycle Begins	
Date MAC Will Accept Written Appeals Requests (Redeterminations)	
First Anticipated MAC Payment Date	
Date MAC Begins Customer Service	

Provisions in the Affordable Care Act of 2010 (ACA)

MLN Matters® Number: SE1023
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

All providers that bill Medicare for services provided to Medicare beneficiaries.

Provider Action Needed

Providers should be aware of these provisions and frequently visit the CMS website for updates on their implementation.

Background

The ACA, signed into law on March 23, 2010, includes a number of provisions designed to help physicians. Some of those changes are reflected in the Notice of Proposed Rule Making (NPRM), CMS-1503-P. (CMS is accepting comments on the proposed rule until August 24, 2010, and will

respond to them in a final rule to be issued on or about November 1, 2010, that sets forth the policies and payment rates effective for services furnished to Medicare beneficiaries on or after January 1, 2011.)

Provisions in the ACA

Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

The ACA extends the preventive focus of Medicare coverage, which currently pays for a one-time only initial preventive physical examination (also known as the "Welcome to Medicare Visit"). Medicare will cover annual wellness visits where beneficiaries receive personalized prevention plan services.

Elimination of Deductible and Coinsurance For Most Preventive Services

Effective January 1, 2011, the ACA waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services, specifically for Medicare covered preventive services that have been recommended with a grade of A ("strongly recommends") or B ("recommends") from the U.S. Preventive Services Task Force, as well as the initial preventive physician examination and the annual wellness visit. The ACA also waives the Part B deductible for colorectal cancer screening tests that become diagnostic.

Incentive Payments to Primary Care Practitioners for Primary Care Services

The ACA authorizes CMS to make incentive payments equal to 10 percent of the provider's allowed charges for primary care services furnished by certain physician and non-physician specialties that are designated as primary care practitioners. This provision begins with calendar year 2011. Primary care practitioners are physicians (1) who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's allowed charges under Part B for a prior period as determined by the Secretary of Health and Human Services.

Incentive Payments for General Surgery Services in Rural Areas

The ACA calls for a payment incentive program to improve access to major surgical procedures – defined as those with a 10-day or 90-day global period under the Medicare Physician Fee Schedule – in Health Professional Shortage Areas (HPSAs) between January 1, 2011, and December 31, 2016. To be eligible for the incentive payment, you must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the payment for the surgical services furnished by the general surgeon occurring in a zip code that is located in an area designated as a primary care HPSA.

Revisions to the Practice Expense Geographic Adjustment (PE GPCI) to Assist Rural Providers

The ACA limits recognition of local differences in employee wages and office rents in the PE GPCIs for calendar years 2010 and 2011 as compared to the national average. Localities are held harmless to any decrease in 2010 and 2011 in their PE GPCIs that would result from this alternative methodology. The new law also establishes a permanent 1.0 floor for the PE GPCI for frontier states (Montana, Wyoming, Nevada, North Dakota, and South Dakota), raising the rural area payment for physicians' services to be no less than the national average.

Physician Self-Referral for Certain Imaging Services

The ACA amends the in-office ancillary services exception to the self-referral law as applied to advanced imaging services, such as magnetic resonance imaging, computed tomography, and positron emission tomography, to require a physician to disclose to a patient in writing at the time of the referral that there are other suppliers of these imaging services, along with a list of other suppliers in the area in which the patient resides.

Misvalued Codes Under the Physician Fee Schedule

The ACA requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. Building on this authority, the new rule identifies additional categories of services that may be misvalued, including codes with low work relative value units (RVUs) commonly billed in multiple units per single encounter and codes with high volume and low work RVUs.

Modification of Equipment Utilization Factor for Advanced Imaging Services

The ACA adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment to more consistently reflect the typical actual use of the equipment and, thereby, reduces payment rates for the associated procedures. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the ACA increases the established multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Maximum Period for Submission of Medicare Claims Reduced to Not More than 12 Months

The ACA changes the time frame during which claims may be submitted for physicians' services to one year from the date of service, beginning with services furnished on or after January 1, 2010. This reflects a reduction in the maximum prior timely filing deadline of 15 to 27 months and aims to improve prompt payment and improve program integrity.

Additional Information

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

You can find information (as of June 11, 2010) on CMS published regulations, CMS policy instructions, key implementation dates, and other accomplishments that relate to ACA at https://www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf on the CMS website.

Many of the new provisions outlined in the ACA are reflected in the proposed Medicare Physician Fee Schedule regulation, which can be found at http://www.federalregister.gov/inspection.aspx on the Internet.

You can also find a beneficiary brochure that provides information about the services and benefits of the new health care law (Medicare and the New Health Care Law — What it Means for You) at http://www.medicare.gov/Publications/Search/Results.asp?PubID=11467&Type=PubID on the Internet.

Competitive Bidding

Durable Medical Equipment National Competitive Bidding Implementation -- Phase 10C: Exception for Medicare Beneficiaries Previously Enrolled in a Medicare Advantage Plan

MLN Matters® Number: MM6918 *Revised*
Related Change Request (CR) #: 6918
Related CR Release Date: June 18, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R721OTN
Implementation Date: October 4, 2010

Note: This article was revised on June 21, 2010, to reflect the revised CR 6918 that was issued on June 18, 2010. The article was changed to include a revised first bullet point in the "Key Points of CR 6918" section. Also, the CR release date, transmittal number, and the Web address for accessing CR 6918 were revised. All other information remains the same.

Provider Types Affected

Suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries are impacted by this issue.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6918 to alert providers that under certain circumstances Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) payment will be allowed for grandfathered items for beneficiaries who received services from a DMEPOS supplier while under a Medicare Advantage plan. Those items should be furnished by a non-contract Medicare Advantage (MA) supplier under the DMEPOS Competitive Bidding Program for a beneficiary who resides in a competitive bidding area (CBA) and elects to leave their MA plan or loses his/her coverage under this plan. Such beneficiary may continue to receive items requiring frequent and substantial servicing, capped rental, oxygen and oxygen equipment, or inexpensive or routinely purchased rented items from the same DME supplier under the MA plan without going to a contract supplier under the Medicare DMEPOS Competitive Bidding Program.

However, the supplier from whom the beneficiary previously received the item under the plan must be a Medicare enrolled supplier; meet the Medicare fee for service (FFS) coverage criteria and documentation requirements; and elect to become a grandfathered supplier.

Key Points of CR6918

- Medicare will pay oxygen claims that qualify for the MA plan grandfathering at the Round One bid amount and will pay capped rental claims that qualify for the MA plan grandfathering at the fee schedule amount during the Round One contract period. The target implementation date for the Round One Rebid is January 1, 2011, and is subject to change.
- The beneficiary must have been enrolled in a MA plan on the day prior to the start date for the Round One Rebid to qualify for the MA plan grandfathering exception.

Background

The Medicare DMEPOS Competitive Bidding Program was established by section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) which amended section 1847 of the Social Security Act (the Act) to require the Secretary of Health and Human Services to establish and implement programs under which competitive bidding areas (CBAs) are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items and services for which payment is made under Medicare Part B.

Section 1847(a)(4) requires that in the case of covered DME items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary must establish a "grandfathering" process by which rental agreements for the DME covered items and oxygen are entered into before the start of the competitive bidding program may be continued.

Additional Information

If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website. The official instruction associated with this CR6918, issued to your Medicare DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R721OTN.pdf on the CMS website.

To review the complete listing of links to DME related information you may go to http://www.cms.gov/center/dme.asp on the CMS website.

Payment of Oxygen Contents to Suppliers after the 36th Month Rental Cap under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

MLN Matters® Number: MM6939
Related Change Request (CR) #: 6939
Related CR Release Date: April 27, 2010
Effective Date: October 1, 2010 for Medicare system changes
Related CR Transmittal #: R676OTN
Implementation Date: October 4, 2010

Provider Types Affected

This article is for suppliers who have received payment for the 36th continuous use of oxygen equipment for a Medicare patient and billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen contents used with that liquid or gaseous oxygen equipment (stationary or portable).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6939 to alert suppliers that Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment for any period of medical need after the payment cap for the remainder of the reasonable useful lifetime of the equipment. This requirement continues to apply under the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a competitive bidding area (CBA)). See the Key Points section of this article for more of the specifics of CR6939.

Background

On July 15, 2008, section 144(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(a)(5)(F) of the Social Security Act (the Act) to repeal the transfer of ownership provision established by the Deficit Reduction Act of 2005 for oxygen equipment and establish new payment rules and supplier responsibilities after the 36 month payment cap. One of the MIPPA 144(b) provisions requires that Medicare payment for oxygen contents used with liquid or gaseous oxygen equipment (stationary or portable) continue after the 36-month rental cap. As further defined in Federal Regulations (42 CFR 414.226(f)(2)), the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period of medical need for the remainder of the reasonable useful lifetime established for the equipment. If a beneficiary relocates, the supplier that received the payment for the 36th continuous month must arrange for furnishing the oxygen contents with another supplier if the beneficiary relocates to an area that is outside the normal service area of the supplier. This MIPPA requirement for the supplier that received the 36th month payment to continue furnishing oxygen contents during any period of medical need for the remainder of the reasonable useful lifetime remains in effect regardless of whether the beneficiary resides in a CBA or the oxygen supplier is a contract, non-contract or grandfathered supplier under the DMEPOS competitive bidding program.

Key Points of CR6939

- If a beneficiary travels or temporarily relocates to a CBA, the oxygen supplier that received the payment for the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.
- The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.
- The changes specified in this CR6939 are in preparation for the DMEPOS Competitive Bidding Program Round One Rebid (the Round One Rebid) implementation. The target implementation date for the Round One Rebid is January 1, 2011 and is subject to change. CMS will send notification of the actual start date for the Round One Rebid in a separate instruction.
- Remember claims will be denied for both base oxygen equipment and related oxygen contents claims from non-contract suppliers in CBAs when the initial date on the beneficiary's oxygen Certificate of Medical Necessity (CMN) is on or after the start date for the Round One Rebid. Medicare will also deny such claims from non-contract suppliers when the rental period for the base oxygen equipment began on or after the start date of the Round One Rebid.
- **NOTE:** CR6939 provides instructions for processing oxygen contents claims received from a supplier when the beneficiary resides in a CBA and the 36-month payment cap has been reached for the related base equipment. The CR6939 does not address situations in which a beneficiary travels or temporarily relocates to a CBA. Moreover, it does not address the oxygen claim payment policies applicable to beneficiaries who do not reside in a CBA. The claims processing instructions related to these policies will be provided in a subsequent CR.

Additional Information

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

The official instruction associated with this CR6939 issued to your Medicare MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R676OTN.pdf on the CMS website.

To review the CMS DME website that provides a complete listing of links to DME related information you may go to http://www.cms.gov/center/dme.asp on the CMS website.

HCPCS, Fees, & ASP

Quarterly Healthcare Common Procedure Coding System (HCPCS) Code Changes – July 2010 Update

MLN Matters® Number: MM6809 *Revised*
Related Change Request (CR) #: 6809
Related CR Release Date: May 21, 2010
Effective Date: July 1, 2010 unless otherwise specified
Related CR Transmittal #: R1972CP
Implementation Date: July 6, 2010

Note: This article was revised on May 27, 2010, to correct the long description for HCPCS Code Q2025 on page 2. The description was corrected to show 1mg. Also, reference to code WW141 was deleted. All other information is the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6809 which provides the Quarterly Healthcare Common Procedure Coding System (HCPCS) Code changes for the July 2010 Update. Be sure your billing staff know of these HCPCS code changes as noted below.

Background

6809 describes the process for updating these specific HCPCS codes.

Effective for claims with dates of service on or after July 1, 2010, the following HCPCS code will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2025	Oral fludarabine phosphate	Fludarabine phosphate, oral, 1mg	E

Note that suppliers are currently instructed to bill oral anti-cancer drugs to the DME MACs using the appropriate National Drug Code (NDC).

In addition, the Centers for Medicare & Medicaid Services (CMS) recently concluded that Dermal injections for facial lipodystrophy syndrome (LDS) are only reasonable and necessary using dermal fillers approved by the Food and Drug Administration for this purpose, and then only in HIV infected beneficiaries when facial LDS caused by antiretroviral HIV treatment is a significant contributor to their depression. Consequently, effective for claims with dates of service on or after March 23, 2010, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description	MPFSDB Status Indicator
Q2026	Radiesse injection	Injection, Radiesse, 0.1ml	E
Q2027	Sculptra Injection	Injection, Sculptra, 0.1ml	E

Additional Information

Medicare contractors will not search their files to reprocess claims already processed, but will adjust such claims that you bring to their attention. The official instruction, CR 6809, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1972CP.pdf on the CMS website. If you have any questions, please contact your carrier, FI, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Addition of Repair Codes to the List of Healthcare Common Procedure Coding System (HCPCS) Codes Payable Under the Instructions Provided in Change Requests (CRs) 6573 and 5917

MLN Matters® Number: MM6914
Related Change Request (CR) #: 6914
Related CR Release Date: April 30, 2010
Effective Date: January 1, 2010
Related CR Transmittal #: R695OTN
Implementation Date: October 4, 2010

Provider Types Affected

This article applies to suppliers billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 6914 in order to augment previously issued CR 6573. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers may bill separately for any of the repair codes listed in the Key Points section of this article in addition to the codes for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME previously communicated in Attachment A of CR 6573. Your Medicare contractors will reprocess any claims submitted

by DMEPOS suppliers for these separately billable repair codes listed below with dates of service of January 1, 2010, through the implementation date of CR 6914 (which is October 4, 2010), according to the guidelines established in CRs 5917 and 6573.

Key Points of CR6914

- The following is the list of the additional separately billable repair codes issued within CR6914

Code	Description
K0739	Repair or non-routine service for Durable Medical Equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes
L7500	Repair of prosthetic device, hourly rate
L7510	Repair of prosthetic device, repair or replace minor parts
L7520	Repair prosthetic device, labor component, per 15 minutes
L8627	Cochlear implant, external speech processor, component, replacement
L8628	Cochlear implant, external controller component, replacement
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device
Q0506	Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device replacement only

- Medicare contractors will allow suppliers that are dually enrolled with the National Supplier Clearinghouse (NSC) and with their local carrier or A/B MAC as DMEPOS suppliers to bill separately for any of the above listed DMEPOS repair codes as well as those codes included in Attachment A of CR 6573 when billed under the guidelines established in CRs 5917 and 6573, including items/services furnished to beneficiaries who reside in other States.
- CR 5917 may be reviewed at http://www.cms.gov/Transmittals/downloads/R1603CP.pdf and CR 6573 http://www.cms.gov/Transmittals/downloads/R531OTN.pdf on the CMS website.

Additional Information

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

The official instruction associated with this CR6914, issued to your Medicare MAC or carrier regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R695OTN.pdf on the CMS website.

You may review MM6573 (related to CR 6573) at http://www.cms.gov/MLNMattersArticles/downloads/MM6573.pdf and MM5917 (related to CR 5917) at http://www.cms.gov/MLNMattersArticles/downloads/MM5917.pdf on the CMS website.

July Quarterly Update for 2010 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters® Number: MM6945
Related Change Request (CR) #: 6945
Related CR Release Date: July 1, 2010
Effective Date: January 1, 2010 for implementation of fee schedule amounts for codes in effect on January 1, 2010; April 1, 2010 for the revisions to the RA & RB modifier descriptors which became effective April 1, 2010; July 1, 2010 for all other changes.
Related CR Transmittal #: R1993CP
Implementation Date: July 6, 2010

Note: This article was revised on July 1, 2010, to reflect changes made by the release of an updated Change Request (CR) 6954. Language on page 2 in bold was corrected to state that claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 will be adjusted if brought to the contractor's attention. In addition, the Transmittal number, CR release date, and web address for the CR has been changed. All other material remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6945 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to correct any fee schedule amounts for existing codes. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by Sections 1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in 42 CFR 414.102.

Key Points of CR6945

- Healthcare Common Procedure Coding System (HCPCS) codes A4336, E1036, L8031, L8032, L8629 and Q0506 were added to the HCPCS file effective January 1, 2010. The fee schedule amounts for the aforementioned HCPCS codes are established as part of this update and are effective for claims with dates of

service on or after January 1, 2010. These items were paid on a local fee schedule basis prior to implementation of the fee schedule amounts established in accordance with this update. Claims for codes A4336, E1036, L8031, L8032, L8629 and Q0506 with dates of service on or after January 1, 2010 that have already been processed may be adjusted to reflect the newly established fees if brought to the attention of your Medicare contractor.

- CMS notes that they have received questions requesting clarification concerning what items and services a supplier must furnish when billing HCPCS code - A4221 Supplies for Maintenance of Drug Infusion Catheter, Per Week. To restate existing policy, all supplies (including dressings) used in conjunction with a durable infusion pump are billed with codes A4221 and A4222 or codes A4221 and K0552. Other codes should not be used for the separate billing of these supplies. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding the insulin reservoir) related to continuous subcutaneous insulin infusion via an external insulin infusion pump and the infusion sets and dressings related to subcutaneous immune globulin administration. The payment amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the beneficiary for that week. Suppliers that bill HCPCS code A4221 are required to furnish the items and services described by the code in the quantities needed by the beneficiary for the entire week.
- CR6945 also clarifies that modifiers RA and RB, for repair and replacement of an item, added to the HCPCS code set effective January 1, 2009, are also available for use with prosthetic and orthotic items. Additionally, the descriptors for RA and RB are being revised, effective April 1, 2010, to read as follows:
  - **RA-** Replacement of a DME, Orthotic or Prosthetic Item
  - **RB-** Replacement of a Part of a DME, Orthotic or Prosthetic Item Furnished as Part of a Repair

  Suppliers should continue to use the RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged. Likewise, the RB modifier should continue to be used on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device.)
- Under the regulations at 42 CFR 414.210(f), the reasonable useful lifetime of DMEPOS devices is 5 years unless Medicare program/manual instructions authorize a specific reasonable useful lifetime of less than 5 years for an item. After a review of product information and in consultation with the DME MAC medical officers, CMS has determined that a period shorter than 5 years more accurately reflects the useful lifetime expectancy for a reusable, self-adhesive nipple prosthesis. CR6945 lowers the reasonable useful lifetime period for a reusable, self-adhesive nipple prosthesis to 3 months.
- HCPCS code Q0506 Battery, Lithium-Ion, For Use With Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only was added to the HCPCS effective January 1, 2010. Based on information furnished by ventricular assist device (VAD) manufacturers, CMS determined that the reasonable useful lifetime of the lithium ion battery described by HCPCS code Q0506 is 12 months. Therefore, CR 6945 is establishing edits to deny claims that are submitted for code Q0506 prior to the expiration of the batteries' reasonable useful lifetime. The reasonable useful lifetime of VAD batteries other than lithium ion – HCPCS codes Q0496 and Q0503 – remains at 6 months as described in CR3931, Transmittal 613, issued July 22, 2005. Additionally, suppliers and providers will need to add HCPCS modifier RA (Replacement of a DME, Orthotic or Prosthetic Item) to claims for code Q0506 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged. Per the VAD replacement policy outlined in CR3931, if the A/B MAC, local carrier, or intermediary determines that the replacement of the lost, stolen, or irreparably damaged item is reasonable and necessary, then payment for replacement of the item can be made at any time, irrespective of the item's reasonable useful lifetime.

Additional Information

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

The official instruction (CR6945) issued to your Medicare DME MAC may be found at http://www.cms.gov/transmittals/downloads/R1993CP.pdf on the CMS website.

October 2010 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Number: MM7007
Related Change Request (CR) #: 7007
Related CR Release Date: June 18, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R1990CP
Implementation Date: October 4, 2010

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7007 and instructs Medicare contractors to download and implement the October 2010 ASP drug pricing file for Medicare Part B drugs; and, if released

by the Centers for Medicare & Medicaid Services (CMS), also the revised, July 2010, April 2010, January 2010 and October 2009 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 4, 2010, with dates of service October 1, 2009, through December 31, 2010. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

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

Files	Effective Dates of Service
October 2010 ASP and ASP NOC files	October 1, 2010, through December 31, 2010
July 2010 ASP and ASP NOC files	July 1, 2010, through September 30, 2010
April 2010 ASP and ASP NOC files	April 1, 2010, through June 30, 2010
January 2010 ASP and ASP NOC files	January 1, 2010, through March 31, 2010
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

Additional Information

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

The official instruction (CR7007) issued to your Medicare MAC, carrier, and/or FI may be found at http://www.cms.gov/Transmittals/downloads/R1990CP.pdf on the CMS website.

CMS News Flash

The revised, Guided Pathways to Medicare Resources (1st Quarter 2010), are now available from the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network. Guided Pathways leads Medicare Fee-For-Service providers through a variety of resources organized by topic. Quickly explore these three easy-to-navigate online guides to learn important Medicare policy and requirements. Guided Pathways information is available at http://www.cms.gov/MLNEdWebGuide/30_Guided_Pathways.asp on the CMS website.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), which creates a 3% add-on to payments made for home health services to patients in rural areas. The add-on applies to episodes ending on or after April 1, 2010, through December 31, 2016. Similar to temporary rural add-on provisions in the past, claims that report a rural state code (code beginning with 999) as the Core Based Statistical Area (CBSA) code for the beneficiary's residence will receive the additional 3% payment. The CBSA code is reported associated with value code 61 on home health claims. The Centers for Medicare & Medicaid Services is working to expeditiously implement the home health rural add-on provision, Section 3131(c), of the PPACA. Be on the alert for more information about this provision and its impact on past and future claims.

The Medicare Fraud and Abuse Web-based Training Course has been revised and is now available - The course provides information helpful for Medicare providers and suppliers involved in providing and billing for services to people with Medicare. This activity provides information that will increase awareness of Medicare fraud and abuse; provide information regarding correct billing practices, and help Medicare providers, suppliers and staff to file claims correctly. The course offers continuing education credits; please see the course description page for details. To access the course, go to the MLN Products page at http://www.cms.gov/MLNProducts/, and select the web-based training modules link in the "Related Links Inside CMS" section. Once the web-based training courses page is displayed, select the Medicare Fraud and Abuse WBT from the list provide.

Declare your independence from the paper enrollment process – use Internet-based PECOS! Learn how at http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the Centers for Medicare & Medicaid website.

Follow CMS on Twitter to get the latest updates on information you need know about CMS (including Medicare Learning Network updates). Visit http://www.twitter.com/CMSGov and stay connected! (Twitter handle = @CMSGov).

The Centers for Medicare & Medicaid Services (CMS) has released MLN Matters Special Edition Article #SE1017 to assist all providers that will be affected by Medicare Administrative Contractor (MAC) implementations, or DME MAC transitions due to re-competing DME MAC Contracts. This article updates material contained in MLN Matters Article #SE0837, which was originally issued in November 2008, to reflect current experiences with transitions to a MAC. For more details, please read the article at http://www.cms.gov/MLNMattersArticles/downloads/SE1017.pdf on the CMS website.

The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work—approximately 15 work days after Medicare's reimbursement is made, as stated in MLN Matters Article SE0909 (http://www.cms.gov/MLNMattersArticles/downloads/SE0909.pdf) — before attempting to balance bill their patients' supplemental insurers. That is, do not balance bill until you

have received written confirmation from Medicare that your patients' claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare's intention to cross your patients' claims over.

As a result of the Affordable Care Act (ACA), claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf on the Centers for Medicare & Medicaid Services website.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The Centers for Medicare & Medicaid Services (CMS) is working hard to expeditiously implement the new law. The law's Medicare fee-for-service provisions have varying effective dates and CMS' first priority is to address provisions with the earliest effective dates. CMS is committed to assuring Medicare providers are well informed as early as possible. For that reason, CMS is urging you to be on the alert for notices and instructions from CMS and from your Medicare fiscal intermediary, carrier, or Medicare Administrative Contractor, on forthcoming policy and operational changes as we implement the PPACA.

The fifth annual national administration of the Medicare Contractor Provider Satisfaction Survey (MCPSS) is now underway. If you received a letter indicating that you were randomly selected to participate in the 2010 MCPSS, CMS urges you to take a few minutes to go online and complete this important survey via a secure Internet website. Responding online is a convenient, easy, and quick way to provide CMS with your feedback on the performance of the FFS contractor that processes and pays your Medicare claims. Survey questionnaires can also be submitted by mail, secure fax, and over the telephone. To learn more about the MCPSS, please visit the CMS MCPSS website at http://www.cms.gov/mcpss or read the CMS Special Edition MLN Matters article, SE1005, located at http://www.cms.gov/MLNMattersArticles/downloads/SE1005.pdf on the CMS website.

Attention: All Providers and Suppliers Selected to Participate in the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS). Your chance to complete the MCPSS is running out. CMS needs to hear from you. Now is the time to provide CMS with your feedback on your satisfaction with the performance of the Medicare contractor that processes and pays your fee-for-service (FFS) Medicare claims. If you have questions about the survey, need help completing or accessing the online survey tool, or you no longer have your survey access information, please call the MCPSS Provider Helpline at 1.800.835.7012 or send an email to mcpss@scimetrika.com. Someone on the MCPSS team will be happy to assist you. Survey responses may also be submitted by telephone, fax, or postal mail. Your feedback is urgently needed now. Don't delay. Please respond today! Don't pass up this golden opportunity to let your voice be heard! For more information about the MCPSS, please visit the CMS MCPSS website at http://www.cms.gov/mcpss, or read the CMS MLN Matters Special Edition article, SE1005, at http://www.cms.gov/MLNMattersArticles/downloads/SE1005.pdf featuring the survey.

Beginning with the April 2010 update, the Centers for Medicare and Medicaid Services (CMS) will now post the National Correct Coding Initiative (NCCI) Edit files in Excel 2007 and in text formats. Because Excel 2007 can support a larger number of rows, each code range will be contained in one file as opposed to multiple files. This should correct the incompatibility issues that some users experienced last quarter with the Excel 2003 files. Please be aware that Excel 2003 and earlier versions of the software have a maximum row count of 65,536. Some of the NCCI Edit files exceed the maximum row count. If you do not have Excel 2007, please use the text format to import the data into an application that can support larger files. For more information on NCCI edits and to download the files, visit http://www.cms.hhs.gov/NationalCorrectCodInitEd/ on the CMS website.

The revised Medicare Fraud & Abuse fact sheet (February 2010), directs you to a number of sources of information pertaining to Medicare fraud and abuse, and helps you understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse. It can be downloaded at http://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf from the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network.

The Medicare Preventive Services Resources CD, which contains PDF files of our Medicare Preventive Services educational products on a single convenient CD Rom, is now available for order through the Medicare Learning Network—free of charge! To order a free copy of the CD, please visit the Preventive Services Educational Products page at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the CMS website. Scroll down to the "Related Links Inside CMS" section and click on "MLN Product Ordering."

As stated in the Centers for Medicare & Medicaid Services (CMS) provider listserv messages that were sent last fall concerning Change Requests (CRs) 6417 and 6421, CMS has made available a file that contains the National Provider Identifier (NPI) and the name (last name, first name) of all physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer in the Medicare program and who have current enrollment records in Medicare (i.e., they have enrollment records in Medicare's systems that contain an NPI). This file is downloadable by going to the Medicare provider/supplier enrollment website at http://www.cms.gov/MedicareProviderSupEnroll and clicking on "Ordering/Referring Report" on the left-hand side.

The Medicare Learning Network Video is now on You Tube! Watch the Medicare Learning Network video–now playing on CMS' You Tube channel at http://www.youtube.com/watch?v=GOzh7kpAwUo on the web. This video provides you with information on what the Medicare Learning Network has to offer you in your Medicare business practices as well as other helpful resources that CMS offers to Medicare fee-for-service providers. You can also order your copy of this video on DVD today; visit http://www.cms.gov/MLNGenInfo, scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." It's a great conference presentation!

The Centers for Medicare & Medicare Services (CMS) has launched the official website for the Medicare & Medicaid EHR Incentive Programs. This website provides the most up-to-date, detailed information about the EHR incentive programs. The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals and hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. Bookmark this site and visit http://www.cms.gov/EHRIncentivePrograms/ often to learn about who is eligible for the programs, how to register, meaningful use, upcoming EHR training and events, and much more!

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:** CIGNA Government Services PO Box 20010, Nashville, TN 37202
Provider Customer Service Calls	**IVR (Interactive Voice Response):** 1.866.238.9650 (Mon.-Fri., 7:00a - 9:00p CST; Sat., 6:00a - 4:00p CST) **Customer Service:** 1.866.270.4909 (Mon.-Fri., 7:00a - 9:00p CST) **Hearing Impaired:** 1.888.204.3771 (Mon.-Fri., 7:00a - 9:00p CST)
Beneficiary Customer Service Calls	**Phone:** 1.800.Medicare
Written Inquiries	**Address:** CIGNA Government Services PO Box 20010, Nashville, TN 37202
Claim Reopenings (Adjustments)	**Address:** CIGNA Government Services PO Box 20010, Nashville, TN 37202 **Fax:** 1.615.782.4649 **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:** MedicareOPID@cigna.com Enrollment Status: 1.866.270.4909
Appeals – Redetermination Requests	**Address:** CIGNA Government Services PO Box 20009, Nashville, TN 37202 **Fax:** 1.615.782.4630
Electronic Funds Transfer	**Address:** CIGNA Government Services Attn: EFT-DME PO Box 20010, Nashville, TN 37202
Refunds	**Address:** CIGNA Government Services DME MAC Jurisdiction C PO Box 30629, New York, NY 10087-0629 **Phone:** 1.888.315.6930
Overnight or Special Shipping	**Address:** CIGNA Government Services DME MAC Jurisdiction C Two Vantage Way, Nashville, TN 37228
DME MAC Jurisdiction C website	**Website:** http://www.cignagovernmentservices.com
Advance Determination of Medicare Coverage (ADMC) - Requests	**Address:** CIGNA Government Services 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