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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.
Draft Glucose Monitor LCD Released

On September 23, 2010 the Durable Medical Equipment Medicare Administrative Contractors released a revised draft Glucose Monitor local coverage determination (LCD) (http://www.cms.gov/mcd/results_index.asp?from2=results_index.asp&contractor=14 0&from=Lmrpcontractor&retired=D&name=CIGNA%20Government%20Services%20 (18003,%20DME%20MAC)&letter_range=4&). Glucose monitors represents the second highest policy group in terms of allowed charges – at approx $1.6 billion per year in allowed charges nationally. Moreover, glucose monitors has consistently ranked the #1 or #2 policy group for Comprehensive Error Rate Testing (CERT) program errors. Some of those errors include:

- Failure to document that the test results are used/needed to make adjustments in the beneficiary’s treatment regimen
- Mail order suppliers (by far the largest suppliers of test strips/lancets) routinely sending additional supplies to the beneficiary without checking to see what quantity the beneficiary has remaining
- Suppliers base shipping on what the physician ordered; patients often test less frequently
- Beneficiaries getting supplies from multiple suppliers
- Beneficiaries testing more often than is ordered
- Beneficiaries giving excess supplies to relatives/friends or re-selling supplies (See http://www.teststriprescue.org).

As a result of these issues and the need to update the LCD to reflect the current state of the medical literature with regard to testing frequencies, the medical directors revised the LCD. The main changes relate to the frequency of testing and the use of upgrade modifiers for excess quantities.

The DME MAC medical directors are soliciting comments on this draft policy from physicians, manufacturers, suppliers and other professionals involved in the ordering or provision of these items. It is recommended that you send this draft policy to selected members of your organization for review and comment. If you disagree with any aspect of the policy, you should be very specific and, if possible, offer an alternative indication, guideline, etc. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). A written response is also encouraged if you agree with this policy.

Comments may be submitted in writing or electronically and sent to:

**Address:** Robert D. Hoover, Jr, MD, MPH, FACP
Medical Director, DME MAC Jurisdiction C
CIGNA Government Services
2 Vantage Way, Nashville, TN 37228

**Email:** policycomments@cigna.com
Comments must be received no later than November 8, 2010. Comments may also be presented in person or via teleconference at the open public meeting to be held on:

**Date:** October 26, 2010  
**Time:** 1:00pm – 3:00pm ET  
**Location:** Marriott Baltimore Washington Airport hotel  
1743 West Nursery Road, Baltimore, MD 21090

Interested parties who wish to make presentations of scientific evidence and other relevant information at the public meeting, either in-person or via teleconference, must register in advance, either in writing or electronically. Written requests must include the following information:

- Name, address, telephone number of the presenter  
- E-mail address  
- Name and address of the organization represented (if applicable)  
- Whether presenting in person or via teleconference

Requests to attend may be sent to the address above or registered online at: [http://www.cignagovernmentservices.com/medicare_dynamic/wrkshp/DMEMAC/webinars/formDMEOM.asp?selection=DMEOM](http://www.cignagovernmentservices.com/medicare_dynamic/wrkshp/DMEMAC/webinars/formDMEOM.asp?selection=DMEOM)

Registration, either written or electronic, must be received by October 15, 2010.

Presentations should generally be limited to 10 minutes. A laptop (Windows PC) will be available for presenters who wish to use PowerPoint slides. Presentations must be either on a USB flash drive or CD (both are recommended to ensure compatibility).

Members of the public are invited to attend the open meeting as observers. Observers must also register, either via mail or electronic mail, at the address above.

If unable to attend the meeting in-person, teleconference service will be available. Prior to the meeting, registered participants will be sent the teleconferencing information.

**Robert D. Hoover, Jr., MD, MPH, FACP**  
Medical Director  
Durable Medical Equipment Medicare Administrative Contractor  
Jurisdiction C
CGS Updates

PAP Documentation Requirement Revision - Ineffective Therapy on E0601

Recently questions have been received by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) medical directors regarding the requirements in the Positive Airway Pressure (PAP) local coverage determination (LCD) for documentation of ineffective therapy while on an E0601 device. To clarify when a patient may switch from an E0601 to an E0470 device, the following language will replace the current verbiage in the Documentation Requirements section in an upcoming revision of the PAP LCD. The change will be effective for dates of service on or after August 1, 2010.

Revised Language: For beneficiaries changing from an E0601 to E0470 due to ineffective therapy while on E0601 (either during a facility-based titration or in the home setting), the treating physician must document that both of the following issues were addressed prior to changing to an E0470 device:

A. Interface fit and comfort. An appropriate interface has been properly fit and the beneficiary is using it without difficulty. This properly fit interface will be used with the E0470 device; and,  
B. E0601 pressure settings. The current pressure setting of the E0601 prevents the beneficiary from tolerating the therapy and lower pressure settings of the E0601 were tried but failed to:
   1. Adequately control the symptoms of OSA; or,  
   2. Improve sleep quality; or,  
   3. Reduce the AHI/RDI to acceptable levels.


Medical Policy

Treprostinil Inhalation Solution (Tyvaso®) – Coding & Coverage

Effective for dates of service on or after July 31, 2009 treprostinil inhalation solution and the nebulizer and related accessories used to administer it are covered for the treatment of patients with primary pulmonary hypertension (ICD-9 diagnosis codes 416.0 and 416.8) and who meet the criteria for iloprost as described in the Nebulizers LCD.

Treprostinil inhalation solution is coded J7699KO. One unit of service equals one ampule. The claim should identify the name of the drug and the number of ampules dispensed. The submitted charge for J7699KO should just reflect the drug itself - not the nebulizer or accessories.

The Optineb® ir (Nebu-tec) nebulizer used to administer treprostinil inhalation should be billed with code E0574 (ultrasonic nebulizer). Because E0574 is in the capped rental category, in order for it to be paid by Medicare, it must be billed as a rental (RR modifier). If the Optineb® ir nebulizer is billed as a purchase (NU modifier), it will be denied and the drugs and accessories will also be denied. The submitted charge for code E0574 should just reflect the charges for the nebulizer - not the drug or accessories.

If two Optineb® ir nebulizers are provided and the submitted charges reflect two nebulizers, you must bill 2 units of service on the claim line for E0574RR. Medicare will only pay for one nebulizer.

Accessories used in conjunction with the Optineb® ir nebulizer should be billed on separate claim lines. The dome and mouthpiece should be billed with code A7016. Other accessories should be billed with code A9999. When code A9999 is used, the claim must clearly describe the type and quantity of accessories provided.

This information will be added to the next revision of the Nebulizers policy. For additional coverage, coding, and documentation requirements, suppliers should refer to the Nebulizer LCD and related Policy Article on the DME MAC websites.

Suppliers should review the entire Nebulizer policy for additional information on coding, coverage and documentation requirements for these devices: http://www.cms.gov/mcd/search.asp?from2=search.asp&.

Aztreonam Lysine (Cayston®) Inhalation Solution - Coding & Coverage

Aztreonam lysine (Cayston®) is an inhalation solution that is indicated for patients with cystic fibrosis with chronic Pseudomonas aeruginosa infection.

Aztreonam lysine is coded J7699KO. For the units of service, indicate the number of ampules that are dispensed - e.g., 28. The claim should identify the name of the drug and the number of ampules dispensed.

Aztreonam lysine is FDA-approved for administration only with the Altera® (Pari) nebulizer. It has been determined that the Altera nebulizer is not sufficiently durable to meet the statutory requirements for coverage under the DME benefit. This item must be coded and billed using HCPCS code A9970, noncovered item or service. Claims will be denied as noncovered (no Medicare benefit). Because the Altera nebulizer is noncovered, claims for aztreonam lysine inhalation solution and related accessories will also be denied as noncovered.

Suppliers should review the entire Nebulizer policy for additional information on coding, coverage and documentation requirements for these devices: http://www.cms.gov/mcd/search.asp?from2=search.asp&.
Therapeutic Shoes – Policy Revision/Documentation Requirements

A revision of the Therapeutic Shoes Policy Article (PA) has been released. In addition, the following revision to the Documentation Requirements section of the LCD is being made. It will be incorporated in a subsequent revision of the Therapeutic Shoes LCD.

An order for each item billed must be signed and dated by the prescribing physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

If the prescribing physician is the supplier, a separate order is not required, but the item provided must be clearly noted in the patient’s record.

A new order is not required for the replacement of an insert or modification within one year of the order on file. However, the supplier’s records should document the reason for the replacement. A new order is required for the replacement of any shoe. A new order is also required for the replacement of an insert or modification more than one year from the most recent order on file. For claims with dates of service on or after January 1, 2011, the detailed written order must be signed on or after the date of the visit with the Prescribing Physician (see related Policy Article for information about the visit with the Prescribing Physician).

The supplier must obtain a signed statement from the physician who is managing the patient’s systemic diabetes condition (i.e., the certifying physician) specifying that the patient has diabetes mellitus, has one of conditions 2a-2f listed in the related Policy Article, is being treated under a comprehensive plan of care for his/her diabetes, and needs diabetic shoes. The certifying physician must be an M.D. or D.O and may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist. The “Statement of Certifying Physician for Therapeutic Shoes” form (see LCD Attachments section below) is recommended. Whatever form is used must contain all of the elements contained on the recommended form attached to this LCD. This statement must be completed, signed, and dated by the certifying physician and must be received by the supplier prior to claim submission. A new Certification Statement is required for a shoe, insert or modification provided more than one year after the most recent Certification Statement on file.

There must be information in the medical records of the certifying physician that:

a. Documents management of the patient’s diabetes; and
b. Documents detailed information about the condition (2a-2f listed in the related Policy Article) that qualifies the patient for coverage.

The Certification Statement by itself does not meet this requirement for documentation in the medical records.

The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 4) must include at least the following:

1. An examination of the patient’s feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient’s feet.
3. For custom molded shoes (A5501) and inserts (A5513), 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 evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

The ICD-9 code that justifies the need for these items must be included on the claim.
These revisions address two main areas:

- **In-person fitting and delivery.** This requirement is included in the DMEPOS Quality Standards published in October 2008. This policy revision incorporates information that was published in an article in May 2010.
- **Certification statement.** The Medicare statute – Social Security Act, Title XVIII, Section 1861(s)(12) – states that the physician who is managing the individual’s diabetic condition must (1) document that the patient has one of several specified conditions that predispose the patient to diabetic ulcers of the feet and (2) certify that the individual needs therapeutic shoes and inserts under a comprehensive plan of care related to their diabetes. The DME MACs have received a number of questions relating to the timing and sequencing of visits and other activities related to this requirement. The policy revision clarifies these requirements.

The statute, national policy, and LCD/PA identify three entities involved in the provision of therapeutic shoes: Certifying Physician, Prescribing Physician, and Supplier. Definitions of these entities are found in the Therapeutic Shoes Policy Article. The following table summarizes the sequence and timing of the various steps required for the coverage of therapeutic shoes and inserts.

**Note:** The information contained in this article is only a summary of requirements. For complete information, you must review the entire LCD and Policy Article at [http://www.cms.gov/mcd/search.asp?from2=search.asp](http://www.cms.gov/mcd/search.asp?from2=search.asp).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Person</th>
<th>Requirements¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Visit to document diabetes management²</td>
<td>Certifying MD/DO</td>
<td>Within 6 months prior to delivery</td>
</tr>
<tr>
<td>2 Visit to document qualifying foot condition²</td>
<td>Certifying MD/DO, other MD/DO, DPM, PA, NP, CNS</td>
<td>Within 6 months prior to delivery</td>
</tr>
</tbody>
</table>
| 3 Completing Certification Statement              | Certifying MD/DO                        | After visit(s) to document diabetes management and qualifying foot condition²  
|                                                  |                                        | After Certifying Physician reviews and signs report of visit documenting qualifying foot condition by other MD/DO, DPM, PA, NP, CNS – if applicable³  
|                                                  |                                        | Prior to initial provision of shoes and inserts  
|                                                  |                                        | For subsequent provision of shoes and inserts, required if delivery is more than 1 year after most recent Certification Statement |
| 4 Providing dispensing order to supplier⁴         | Prescribing physician                   | After visit with Prescribing physician  
|                                                   |                                        | Before delivery |
| 5 Signing detailed written order                   | Prescribing physician                   | After visit with Prescribing physician |
| 6 Selection visit                                  | Supplier                               |                                             |
| 7 Delivery visit                                   | Supplier                               | After selection visit  
|                                                   |                                        | After receiving dispensing order or detailed written order |
| 8 Submitting claim                                 | Supplier                               | After delivery  
|                                                   |                                        | After receiving detailed written order  
|                                                   |                                        | After receiving Certification Statement |

¹ If the table states that one event needs to occur “before” or “after” another event, both could occur on the same date if that sequence was followed

² Effective for dates of service on/after 01/01/2011

³ Applicable if qualifying foot condition is not documented on visit with Certifying Physician

⁴ Separate dispensing order not needed if detailed written order received by supplier prior to delivery

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- Then click on "Join ListServ."
Medicare Policy Regarding Pressure Reducing Support Surfaces

MLN Matters® Number: SE1014 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised and re-issued in its entirety on August 17, 2010.

Provider Types Affected
Suppliers and health care providers, such as home health agencies, who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for pressure reducing support surfaces for Medicare beneficiaries, are affected.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) is issuing Special Edition (SE) 1014 to clarify existing support surface medical policies and coverage requirements. This article does not present new policy, but only reinforces existing policy. Be certain that your billing staffs are aware of these policies as outlined in the Background section of this article.

Background
In August of 2009, the Department of Health and Human Services (HHS), Office of Inspector General (OIG) issued a report entitled “Inappropriate Payments for Pressure Reducing Support Surfaces” (report numbered OEI-02-07-00420), regarding the inappropriate billing for Pressure Reducing Support Surfaces by Durable Medical Equipment Prosthetics Orthotics Supplies (DMEPOS) suppliers. The purpose was to determine the extent of inappropriate Medicare payments for pressure reducing support surfaces and to assess supplier compliance with DME MAC local coverage determinations (LCDs).

Pressure reducing support surfaces are a type of durable medical equipment (DME) used for the care of pressure sores, also known as pressure ulcers. Pressure ulcers are lesions caused by unrelieved pressure resulting in damage of underlying tissue. Support surfaces are coded under one of 16 different Healthcare Common Procedure Coding System (HCPCS) codes. A major distinction between support surfaces is that some are powered by electricity and others are not. They may be categorized into the following three groups:

- **Group 1** support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include mattresses, pressure pads and mattress overlays (foam, air, water, or gel).
- **Group 2** support surfaces are generally designed to either replace a standard hospital or home mattress or as an overlay placed on top of a standard hospital or home mattress. Products in this category include powered air flotation beds, powered pressure reducing air mattresses, and non-powered advanced pressure reducing mattresses.
- **Group 3** support surfaces are complete bed systems, known as air-fluidized beds, which use the circulation of filtered air through silicone beads.

Although LCDs are published by the four DME MAC contractors, inappropriate payments are still being made, and other problems continue to adversely affect Medicare reimbursement for this equipment. Therefore, CMS is taking additional steps listed here to reduce the extent of inappropriate support surface payments.

**Required Documentation in Patient’s Medical Record**
- 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). The information should include the patient’s diagnosis and other pertinent information including, but not limited to, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.
- Suppliers should note that neither physicians’ orders, nor supplier-prepared statements, nor physician attestations by themselves provide sufficient documentation of medical necessity, even though they may be signed by the treating physician or supplier. There must be information in the patient’s medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable). (See Medicare’s Program Integrity Manual (PIM), Chapter 3 (http://www.cms.gov/manuals/downloads/pim83c03.pdf), Section 3.4.1.1, for additional instructions, regarding review of documentation during pre- and post-payment)
- The patient’s medical record is not limited to the physician’s office records. It may include hospital, nursing home, or home health agency (HHA) records and records from other health care professionals.
- The documentation in the patient’s medical record does not have to be routinely sent to the supplier or to the DME MACs, DME Program Safeguard Contractors (PSCs), or Zone Program Integrity Contractors (ZPICs). However, the DME MACs, DME PSCs, or ZPICs may request this information in selected cases.

**Required Supplier’s Documentation**
- Before submitting a support surface claim to the DME MAC the supplier must have on file a dispensing order, the detailed written order, information from the treating physician concerning the patient’s diagnosis, and any information required for the use of specific modifiers or attestation statements as defined in certain DME MAC policies. The supplier should also obtain as much documentation from the patient’s medical record as they determine they need to assure themselves that coverage criteria for an item have been met.
If the information in the patient’s medical record does not adequately support the medical necessity for the item, then on assigned claims the supplier is liable for the dollar amount involved unless a properly executed advance beneficiary notice (ABN) of possible denial has been obtained.

- Documentation must be maintained in the supplier’s files for seven (7) years.
- Suppliers are required to maintain proof of delivery documentation in their files. The three proof of delivery requirements are:
  - Supplier delivering directly to the beneficiary or authorized representative;
  - Supplier utilizing a delivery/shipping service to deliver items; and
  - Delivery of items to a nursing facility on behalf of the beneficiary.
- Proof of delivery documentation must be available to the DME MAC, DME PSC, and ZPIC on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently do not provide documentation to support their services may be referred to the OIG for imposition of civil monetary penalties (CMPs) or administrative sanctions.

**Medicare Coverage of Support Surfaces**

For all three support surface groups, patients should have a care plan established by their physician or home care nurse, which is documented in their medical records. This plan generally should include, among other things, education of the patient and regular assessment by a healthcare practitioner. Coverage for all three groups continues until the patient’s pressure ulcer is healed.

In addition to the above common requirements, coverage for specific groups of support surfaces varies as follows:

- **GROUP 1** - A group 1 support surface is covered if the patient is completely immobile. Otherwise, he or she must be partially immobile, or have any stage pressure ulcer and demonstrate one of the following conditions: impaired nutritional status, incontinence, altered sensory perception, or compromised circulatory status. A physician order must be obtained prior to delivery of the equipment and should be kept on file by the supplier.

- **GROUP 2** - A group 2 support surface is covered if the patient has a stage II pressure sore located on the trunk or pelvis, has been on a comprehensive pressure sore treatment program (which has included the use of an appropriate group 1 support surface for at least one month), and has sores which have worsened or remained the same over the past month. A group 2 support surface is also covered if the patient has large or multiple stage III or IV pressure sores on the trunk or pelvis, or if he or she has had a recent mycuteaneous flap or skin graft for a pressure sore on the trunk or pelvis and has been on a group 2 or 3 support surface.

- **GROUP 3** – A group 3 support surface is covered if the patient has a stage III or stage IV pressure ulcer, is bedridden or chair-bound, would be institutionalized without the use of the group 3 support surface, the patient is under the close supervision of the patient’s treating physician, at least one (1) month of conservative treatment has been administered (including the use of a group 2 support surface), a caregiver is available and willing to assist with patient care and all other alternative equipment has been considered and ruled out.

**Additional Information**

For more information regarding Documentation, refer to the PIM, Chapter 5 (http://www.cms.gov/manuals/downloads/pim83c05.pdf) on the CMS website. In addition, the DME MAC LCDs - Pressure Reducing Support Surface – Group 1, Pressure Reducing Support Surface – Group 2, Pressure Reducing Support Surface – Group 3 may be found on the CMS Medicare Coverage Database at http://www.cms.gov/mcd (search “support surfaces”).

Providers may also want to review the Office of Inspector General (OIG) report, Inappropriate Payments for Pressure Reducing Support Surfaces OEI-02-07-00420. This report may be viewed at http://www.oig.hhs.gov/oei/reports/oei-02-07-00420.pdf.

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.

**Coverage & Billing**

**Positive Airway Pressure (PAP) Devices: Supplier Frequently Asked Questions**

*Question 15 has been updated.*

**Ordering/Treating Physician Issues**

1. **The LCD uses the term “treating physician” in various places. What is the definition of a treating physician?**

   Medicare statute defines treating physician as one “…who furnishes a consultation or treats the beneficiary for a specific medical problem and who uses the [diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests] results in the management of the beneficiary’s specific medical problem.” In a scenario where the beneficiary visits their primary care provider (PCP) who then refers the beneficiary to a sleep specialist for a polysomnogram and subsequent treatment with PAP and follow-up, both the PCP and the sleep specialist would be considered a “treating physician” within the context of Medicare regulations. Both physicians are engaged in diagnosing and treating the beneficiary for sleep disordered breathing. This scenario is quite common in medical practice where the primary medical care for the patient is rendered by the PCP and subspecialty physician consultation is engaged for specific diagnostic and/or therapeutic treatment outside the scope of the PCP’s area of medical expertise.
2. Are nurse practitioners, clinical nurse specialists and physician assistants allowed to conduct the initial clinical evaluation and/or follow-up evaluation since the LCD states this must be done by the treating physician?
Yes. Medicare regulations provide for the use of nurse practitioners, clinical nurse specialists and physician assistants in the care of Medicare beneficiaries. The Social Security Act §1861(s) addresses the provision of Medical and Other Services as follows:

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

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

3. Can a registered nurse (RN) conduct the follow-up evaluation?
No, the treating physician must be directly involved in the follow-up evaluation.

4. The policy states that the data that the physician evaluates must be for a period of 30 consecutive days. The policy is silent on a time frame in which the physician must see the patient in relationship to the data. The physician may see the patient and conduct the follow-up evaluation between the 31st and 91st day. Continued coverage of a PAP device requires that a determination be made by the treating physician that the patient is benefiting from the use of the selected device as evidenced by a face-to-face clinical follow-up evaluation and adherence to therapy. While the documentation of adherence may occur following the treating physician’s follow-up evaluation, the adherence report must be provided to the treating physician for inclusion in the patient’s medical record in order to fulfill the requirement to assess therapy benefit. Consider the following example:

- 11/01/08 Patient set up with a PAP device
- 12/05/08 Face-to-face re-evaluation indicates subjective improvement, but objective data is not available
- 1/30/09 Supplier obtains data demonstrating adherent use; faxes to MD for review

5. Does the treating physician who does the initial face-to-face examination have to write the order for the PAP therapy or can it be ordered by the interpreting physician from the sleep lab? The treating physician that does the initial face-to-face exam does not have to be the same physician that orders the CPAP.

6. Is there a time limit from initial face-to-face evaluation to the sleep study? No time limit is specified in the policy; however, one would anticipate that these two events occur reasonably close together in time, typically within 3 months.

Adherence Monitoring

7. Help us understand the term “visual inspection” as it relates to adherence monitoring. What does this mean and how can it be documented? The LCD was revised to include allowance for visual inspection based on comments that not all suppliers use devices that allow downloading of adherence information. Visual inspection means determining adherence by looking at information on the PAP device’s display screen and documenting the values in a written report. As noted in a prior FAQ, the supplier may contact the beneficiary via telephone and ask them to read values from their device (i.e., phone-in compliance) or the supplier or physician may read the values during a home/office visit. The values must document that the patient is using the device for 4 or more hours per night for 70% of the nights in a consecutive 30-day period.

8. Can we report hours used, for example with information from a device with an hour meter, and meet the requirement for documenting adherence? For example, “Spoke to patient and she states that as of 12/01/08, there are a total of 650 hours on her CPAP machine. She states that she uses the CPAP every night and it is very beneficial. On 11/01/08, the beginning reading was 500 hours. This calculates to 5 hours per night for 30 days.”
No. Devices that simply report “device on” time or “blower on” time will not provide enough information to determine that the PAP device was used ≥ 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.

9. Several manufacturers have devices that report “sessions” of use. Are these types of devices acceptable to meet the LCD requirement for adherence? Possibly, depending on the definition of “session” which can vary based on the manufacturer or the session definition if a user-defined option. For example, consider a device that measures a “session” as use greater than X hours and also reports number of days used.

10. We use devices from a manufacturer that reports adherence information on a rolling 30 day basis.
Information is displayed in a window on the device; however, adherence may vary depending on which 30 day period is examined. How can we use this device and still meet the adherence requirement? Devices that report information on a rolling 30 day interval can be problematic if using visual inspection as the reporting method. One solution is to engage the beneficiary in their care and emphasize the importance of monitoring their therapy, including the potential loss of Medicare reimbursement for their PAP device due to failure to meet the adherence requirements. In the scenario with this specific piece of equipment, the supplier should instruct the beneficiary to monitor their device after the initial 30 days of use and report back to the supplier the point at which they meet the adherence metric.

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

11. Must suppliers continue to document adherence as defined in the LCD after the initial 3 month period? No. Following the initial 3 month trial and documentation of use ≥ 4 hrs. per night on 70% of nights in a 30 consecutive day period, suppliers should document continued use of the device. This may be accomplished via documentation of attestation by the beneficiary.

12. The PAP LCD states “Adherence to therapy is defined as use of PAP ≥ 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.” Can you please clarify whether the ≥ 4 hours per night is continuous use or cumulative use in a 24 hour period? Would a patient who uses the device for 4 hours a night, but has a break in usage of 45 minutes still satisfy the requirements of the LCD? The ≥ 4 hours per night is based on continuous use, with allowances for short breaks (e.g., toileting).

13. A patient was placed on PAP therapy and during the course of their 12 week trial period they were hospitalized for two weeks. How does this impact the requirement for adherence monitoring and timing of the face-to-face follow-up evaluation? The 12 week trial period applies to PAP use in the home setting. If a patient is admitted to an inpatient hospital or skilled nursing facility (SNF), the trial period is suspended. The trial period, including the requirement for adherence monitoring and the timing of the face-to-face re-evaluation (i.e., between the 31st and 91st day) resumes when the patient returns home.

14. Can continued coverage of PAP therapy be extended to patients who come close to meeting the adherence metric requirements but don’t quite achieve all of them in the 90 day timeframe? No. All of the requirements must be met within the 90 day time frame. CMS’ national coverage determination contained specific language that benefit from PAP therapy must be demonstrated in the first 12 weeks in order to provide continued coverage beyond that time. Compliance is a major issue with CPAP; failure of therapy is often related to mask fit, humidification, ramp time, etc. Most of these issues arise in the first few days of treatment and must be aggressively addressed by the supplier and/or treating physician. Even if that takes 4-6 weeks there is still adequate time to achieve the liberal local coverage determination metric of ≥ 4 hours per night on 70% of the nights in a 30 day period.

Reimbursement Issues

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

- If a PAP device is replaced during the 5 year reasonable useful lifetime (RUL) because of loss, theft, or irreparable damage due to a specific incident, there is no requirement for a new clinical evaluation, sleep test, or trial period.
- If a PAP device is replaced following the 5 year RUL, there must be a face-to-face evaluation by their treating physician that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

16. A patient was diagnosed with obstructive sleep apnea and received a PAP device paid for by private insurance. The patient is now enrolled in FFS Medicare and needs a replacement PAP device and/or accessories. What is required for coverage? For beneficiaries who received a PAP device prior to enrollment in FFS Medicare and are now seeking Medicare coverage of either a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test – There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare, that meets the FFS Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories; and,

2. Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary’s medical record that:
   a. The beneficiary has a diagnosis of obstructive sleep apnea; and,
   b. The beneficiary continues to use the PAP device.

If either criteria 1 or 2 above are not met, the claim will be denied as not medically necessary. The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of the beneficiary’s enrollment in FFS Medicare.
17. DME company ABC conducts home sleep tests and then refers patients to DME company XYZ for PAP therapy after the physician makes the diagnosis of obstructive sleep apnea. Since the two companies are not related and DME company XYZ did not conduct the home sleep test, is DME company XYZ allowed to dispense the PAP device based on this test? No, a DME supplier is not a qualified provider of laboratory services; therefore, this is not a valid test for Medicare purposes. According to the PAP LCD, “No aspect of an HST [home sleep test], including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier.” This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests.

18. If a patient is put on a RAD device with less than 30 days left in the initial 91-day period, the LCD indicates that the patient will be given to 120 days after the initiation of PAP therapy to document adherence. If the patient had a face-to-face exam in the 31 to 91-day period while on a CPAP device, must they have another face-to-face exam after they are on RAD? Certainly if they did not have a face-to-face exam in the 31 to 90 days we understand that one would need to be done before the 120th day. Yes, the patient would need to have a follow-up evaluation before the 120th day to determine benefit from the RAD device. This answer is based on the assumption that the reasons the patient changed from a CPAP to RAD is the failure to show clinical benefit with the CPAP device. According to the NCD, continued coverage requires demonstration of therapy benefit within the first 90 days. The LCD recognizes that some patients may require a change in therapy to a RAD device and this transition may happen late in the first 90 day period such that an extension to 120 days is necessary.

19. If compliance is not documented in the first 90 days and the patient then has a new facility-based polysomnogram and face-to-face evaluation with a physician and a new trial period is begun, does a new capped rental period start? No. Standard break-in-need rules apply because there has been no change in the underlying condition that necessitates the PAP therapy. Consequently, a new capped rental period does not begin.

20. Would it be considered use of a blanket Advance Beneficiary Notice (ABN) to have all new PAP patients sign an ABN at the beginning of therapy stating that if they do not get a face-to-face evaluation or refuse to get the follow-up re-examination by their treating physician between the 31st and 91st day that Medicare will deny the claim? Yes, it would be considered a “blanket” ABN if the notice was presented at the beginning of therapy. The supplier may however, after day 60 following the dispensing of the PAP device, present an ABN to the beneficiary if the supplier has knowledge that the beneficiary has not yet met the policy criteria for continued coverage. This ABN should advise the beneficiary that if, by the 90th day of therapy, they do not meet the policy criteria for continue coverage (e.g., adherent to therapy and obtain a follow-up face to face evaluation), Medicare may deny their subsequent claim(s) and that the beneficiary will be liable for payment.

21. What can a supplier do if the patient does not get in to see the treating physician within the 31st-91st day? If the patient received the re-evaluation at a later date and it was documented that the patient was benefiting from the use of the PAP device, the supplier may begin submitting claims with the KX modifier from the date of that re-evaluation. Claims for services in the interim between the 91st day and the date of the re-evaluation must be submitted with the KX omitted.

22. What can be done in a situation where an order is received for PAP therapy but the patient never had a face-to-face evaluation? Can the face-to-face evaluation be done after the sleep test or after initiation of PAP therapy and will that meet our documentation requirements? The NCD and LCD require that prior to initiating PAP therapy, the patient has a clinical evaluation and sleep test. There is a sound clinical rationale for this specific sequence of events; therefore, a face-to-face evaluation performed after the sleep test or after the initiation of PAP therapy would not meet the coverage requirements and a KX modifier must not be added to the claim. Suppliers may obtain an ABN to inform the beneficiary that the PAP device will not be covered since the coverage requirements were not met.

For more information, please refer to the Local Coverage Decision Policies by clicking on the following link: http: //www.cignagovernmentservices.com/jc/coverage/LCDinfo.html Suppliers should contact the Pricing, Data Analysis, and Coding contractor (PDAC) for guidance on the correct coding of specific items.

Policy Article Revision Summary for August 12, 2010

Outlined below are the principal changes to Oxygen and Oxygen Equipment Policy Article that has been revised and posted. Please review the entire LCD and related Policy Article for complete information.

- Oxygen and Oxygen Equipment
- Policy Article
- Revision Effective Date: 07/01/2010
- NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
  - Revised: Coverage for maintenance and servicing, months 37-60.

Note: The information contained in this article is only a summary of revisions to the Policy Article. For complete information on any topic, you must review the LCD and Policy Article. http://www.cms.gov/mcd/search.asp?from2=search.asp&
Dear Physician,

In order for Medicare to provide reimbursement for a power wheelchair (PWC) or power operated vehicle (POV) (scooter), there are several statutory requirements that must be met:

1. There must be an in-person visit with a physician specifically addressing the patient’s mobility needs.
2. There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the patient’s mobility limitation and needs. The results of this evaluation must be recorded in the patient’s medical record.
3. A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven required elements (see below).
4. The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

The in-person visit and mobility evaluation together are often referred to as the “face-to-face examination”.

The complete history and physical examination typically includes:

- History of the present condition(s) and past medical history that are relevant to the patient’s mobility needs in the home:
  - Symptoms that limit ambulation
  - Diagnoses that are responsible for these symptoms
  - Medications or other treatment for these symptoms
  - Progression of ambulation difficulty over time
  - Other diagnoses that may relate to ambulatory problems
  - How far the patient can walk without stopping and with what assistive device, such as a cane or walker
  - Pace of ambulation
  - History of falls, including frequency, circumstances leading to falls, and why a walker isn’t sufficient
  - What ambulatory assistance (cane, walker, wheelchair) is currently used and why it isn’t sufficient
  - What has changed to now require use of a power mobility device
  - Ability to use a manual wheelchair
  - Reasons why a power operated vehicle (scooter) would not be sufficient for this patient’s needs in the home
  - Description of the home setting and the ability to perform activities of daily living in the home
- Physical examination that is relevant to the patient’s mobility needs
  - Weight and height
  - Cardiopulmonary examination
Musculoskeletal examination
- Arm and leg strength and range of motion
Neurological examination
- Gait
- Balance and coordination
- If the patient is capable of walking, the report should include documented observation of ambulation (with use of a cane or walker, if appropriate)

Examples of vague or subjective descriptions of the patient’s mobility limitations include:
- upper extremity weakness
- poor endurance
- gait instability
- weakness
- abnormality of gait
- difficulty walking
- SOB on exertion
- pain
- fatigue
- deconditioned

These types of statements are insufficient and do not objectively address the mobility limitation or provide a clear picture of the patient’s mobility deficits. Objective measurements should be provided.

The evaluation should be tailored to the individual patient’s conditions. The history should paint a picture of your patient’s functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the patient’s ambulatory difficulty or impact on the patient’s ambulatory ability.

It is important to keep in mind that because of the way that the Social Security Act defines durable medical equipment, a power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living within the home. If the wheelchair/POV is needed in the home, the beneficiary may also use it outside the home. However, in your evaluation you must clearly distinguish your patient’s mobility needs within the home from their needs outside the home.

You may elect to refer the patient to another medical professional, such as a physical therapist or occupational therapist, to perform part of the evaluation – as long as that individual has no financial relationship with the wheelchair supplier. However, you do have to personally see the patient before or after the PT/OT evaluation. You must review the report, indicate your agreement in writing on the report, and sign and date the report. If you do not see the patient after the PT/OT evaluation, the date that you sign the report is considered to be the date of completion of the face-to-face examination.

You should record the visit and mobility evaluation in your usual medical record-keeping format. Many suppliers provide forms for you to complete. Suppliers often try to create the impression that these documents are a sufficient record of the in-person visit and medical evaluation. Based upon our auditing experience, most of them are not. That is because they typically contain check-off boxes or space for only brief answers and thus do not provide enough detailed information about the patient’s ambulatory abilities and limitations to allow the Medicare contractor to determine if coverage criteria have been met. Forms such as those developed by the Texas or Florida Academy of Family Physicians are designed to gather selected bits of information and are almost always insufficient. What is required is a thorough narrative description of your patient’s...
current condition, past history, and pertinent physical examination that clearly describes their mobility needs in the home and why a cane, walker, or optimally configured manual wheelchair is not sufficient to meet those needs.

You may write a prescription for a power mobility device ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

1. Beneficiary’s name
2. Description of the item that is ordered. This may be general – e.g., “power operated vehicle”, “power wheelchair”, or “power mobility device”– or may be more specific.
3. Date of completion of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician’s signature
7. Date of physician signature

You must forward a copy of the face-to-face evaluation and your seven-element prescription to the supplier within 45 days from the completion of the face-to-face mobility exam. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to document the severity of your patient’s ambulatory problems.

After the supplier receives your order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. You should review it and, if you agree with what is being provided, sign, date and return it to the supplier. If you do not agree with any part of the detailed product description, you should contact the supplier to clarify what you want the beneficiary to receive.

This information is not intended to serve as a substitute for the complete DME MAC local coverage determination on Power Mobility Devices. It is only a synopsis detailing the highlights of documentation. Refer to the complete LCD and Policy Article on the CMS website at http://www.cms.hhs.gov/mcd/overview.asp for additional information.

Medicare does provide you additional reimbursement (HCPCS code G0372) to recognize the additional time and effort that are required to provide this documentation to the supplier. This code is payable in addition to the reimbursement for your E&M visit code.

Your participation in this process and cooperation with the supplier will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

Paul J. Hughes, M.D.
Medical Director, DME MAC, Jurisdiction A

Adrian M. Oleck, M.D.
Medical Director, DME MAC, Jurisdiction B

Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC, Jurisdiction C

Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC, Jurisdiction D
Oral Anticancer Drugs – Covered Diagnoses - Update

In March 2010, a revised medical policy on Oral Anticancer Drugs was published with an effective date of June 1, 2010. That policy revision defined the ICD-9 diagnosis codes for which each drug would be covered. The policy was revised to be consistent with Medicare’s national coverage policy for Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen. That policy is found in the Medicare Benefit Policy Manual (Internet-only Publication 100-02), Chapter 15, §50.4.5: http://www.cms.gov/Manuals/IOM/list.asp

That policy states that off-label indications are covered in two general situations:

1. The use is (a) supported in any of the following four compendia:  
   - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium – Category 1 or 2A  
   - American Hospital Formulary Service – Drug Information  
   - Thomson Micromedex DrugDex – Class I, Iia, or Iib  
   - Clinical Pharmacology  
   and (b) not listed as unsupported/ not medically accepted in any of the compendia (e.g., Category 3 in NCCN or Class III in DrugDex).

2. The Medicare contractor makes a determination based on its analysis of the published literature from one or more of the 26 journals listed in that section.

A further revision of the Oral Anticancer Drugs Policy Article is being released on August 12, 2010 with the addition of a number of ICD-9 codes. The effective date of this expanded list of diagnosis codes is retroactive to June 1, 2010.

If suppliers or physicians think that there are additional diagnoses that meet the criteria defined in the Medicare Benefit Policy Manual, they may send documentation to:

Robert D. Hoover, Jr., MD, MPH, FACP  
Medical Director, DME MAC Jurisdiction C  
CIGNA Government Services  
2 Vantage Way, Nashville, TN 37228

The documentation should be copies of either the pertinent sections of one of the four compendia or full text versions of published articles from the specified journals. The preference is that these be electronic documents submitted on a disc; however, hard copy printouts are also acceptable.


Urethral Inserts - HCPCS Code A4336 - Coverage & Documentation

Urethral inserts (A4336) are covered for adult females with stress incontinence when basic coverage criteria are met and the patient or caregiver can perform the procedure. They are not indicated for women:

- With bladder or other urinary tract infections (UTI)
- With a history of urethral stricture, bladder augmentation, pelvic radiation or other conditions where urethral catheterization is not clinically advisable
- Who are immunocompromised, at significant risk from UTI, interstitial cystitis, or pyleonephritis, or who have severely compromised urinary mucosa
- Unable to tolerate antibiotic therapy
- On anticoagulants
- With overflow incontinence or neurogenic bladder

If requested, the medical record must contain information that substantiates the need for this item.

This coverage expansion will be incorporated into the next revision of the Urological Supplies LCD.


Modifier JW Use

The Medicare Claims Processing Manual (Internet Only publication 100-4), Chapter 17, Section 40 contains instructions for the use of the JW modifier for discarded drugs and biologicals. The descriptor for the JW modifier reads:

JW - DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT

Wheelchair Options and Accessories - LT & RT modifiers

The Wheelchair Options and Accessories Policy Article currently states:

The right (RT) and left (LT) modifiers must be used when appropriate. If bilateral items (left and right) are provided as a purchase and the unit of service of the code is "each" bill both items on the same claim line using the LT/RT modifiers and 2 units of service. If bilateral items are provided as a rental and the unit of service is "each", bill the items on two separate claim lines with the RT modifier on one line and the LT modifier on the other. If bilateral items are provided as a purchase or rental and the unit of service is "pair", bill both items on the same claim line using the LT/RT modifiers and 1 unit of service.

The Policy Article is being revised to remove the requirement to report the LT and RT modifiers when the unit of service of the code is "pair". The revised last sentence will state:

If bilateral items are provided and the unit of service is "pair", the LT and RT modifiers do not need to be reported.

This applies to HCPCS codes E1010 (power leg elevation system), K0020 (fixed, adjustable height armrests), and K0195 (elevating legrests - for use with capped rental wheelchair base).

This change is effective immediately and will be incorporated in a future revision of the Wheelchair Options and Accessories Policy Article at: http://www.cms.gov/mcd/search.asp?from2=search.asp&.

Documentation Requests in Jurisdiction C

One of the challenges for Medicare contractors is ensuring claims are paid appropriately and one of the best ways is to request and review documentation and/or medical records. There are multiple contractors in Jurisdiction C who request and review documentation/records. It is important for you to understand who they are and to always respond to requests timely. Failure to respond will normally result in a claim denial or request for a refund.

Below is a list of the contractors who send documentation requests in Jurisdiction C:

- CIGNA Government Services, LLC (CGS) – DME MAC
- CERT Documentation Contractor
- Safeguard Services, LLC – Zone Program Integrity Contractor (ZPIC)
- Health Integrity, LLC - Zone Program Integrity Contractor (ZPIC)
- AdvanceMed Corp. - Zone Program Integrity Contractor (ZPIC)
- Connolly Consulting Associates, Inc. – Recovery Audit Contractor (RAC)

Below are important TIPS for handling the requests:

- Read each request letter carefully.
- Note the due date given in the letter. (Denials will often occur if a response is not received within the stated timeframe.)
- Note where to send your response and be sure to respond to the correct office. (Delays and possible denials will occur if you respond to the wrong office.)
- For prepayment claims, put the request letter on top of the documents you include in your response. This helps ensure your documents are routed appropriately when received at the contractor. (Prepayment means the claim has not completed processing yet.)
- Respond only one time. Don’t send your response multiple times.
- Do not combine responses. If the request letter asks for documentation on just one claim, only include documentation for that claim in your response.
- Send all documents for your response at one time. Don’t send part now and part later.
- Do not file duplicate claims. Keep track when you have received a request for additional documentation on a prepayment claim. Do not file another claim for the same items just because you have not received a response as quickly as a claim where documentation was not requested.
- Remember the contractors normally have longer time limits to review claims where additional documentation was requested. Time limits will vary depending on the contractor, but generally the Centers for Medicare & Medicaid Services (CMS) allows at least 60 days for contractors to complete the reviews once the documentation/records are received.

Each of these contractors has a website, so information is easily accessible about each one. Visit the CGS website at: http://www.cignagovernmentservices.com/jc/index.html under the Customer Service/Helpful Links section for links to the other contractors.

Following is a link to a Medicare Claim Review Programs booklet from the Centers for Medicare & Medicaid Services (CMS) which may also provide helpful information for you: http://www.cms.hhs.gov/MLNProducts/downloads/MCRP_Booklet.pdf.

Payment for Replacement of Oxygen Equipment in Bankruptcy Situations

MLN Matters® Number: MM6838
Related Change Request (CR) #: 6838
Related CR Release Date: April 30, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: 1961CP
Implementation Date: October 4, 2010

Provider Types Affected

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) submitting claims to Medicare contractors (Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (MACs) and DME MACs) for oxygen and oxygen equipment provided to Medicare beneficiaries are affected.
Provider Action Needed
This article is based on Change Request (CR) 6838 and informs suppliers of DMEPOS that Medicare contractors may make payment for replacement oxygen equipment in the event that a supplier files for Chapter 7 or 11 bankruptcy in a United States Bankruptcy Court. Please be sure that your billing staffs are aware of this change.

Background
CR 6838 adds Section 50.4 to Chapter 20 of the Medicare Claims Processing Manual to provide instructions, regarding payment for the replacement of oxygen equipment in the event that a supplier files for Chapter 7 or 11 bankruptcy under Title 11 of the United States Code and is unable to continue furnishing oxygen and oxygen equipment to patients.

In accordance with 42 CFR Sections 414.210(f) and 414.226(g), payment can be made for replacement of oxygen equipment if the equipment has been in continuous use by the patient for the equipment’s reasonable useful lifetime or has been lost, stolen or irreparably damaged, resulting in a new reasonable useful lifetime period and a new 36 month rental payment period.

Payment Documentation Requirements
Medicare contractors are to verify supporting documentation and consider oxygen equipment as lost in certain bankruptcy situations. Payment may then be provided for the replacement of oxygen equipment and a new reasonable useful lifetime period and a 36 month rental payment period may begin on the date that the new, replacement equipment is furnished.

Similar to other situations where oxygen equipment is lost, stolen, or irreparably damaged, the contractor must verify that following claims information is included and valid with the claim:
- The most recent test date and blood gas testing result,
- Oxygen Certificate of Medical Necessity (CMN),
- The Healthcare Common Procedure Coding System (HCPCS) code for the new oxygen equipment (Stationary oxygen equipment - E0424, E0439, E1390, E1391, E1405 or E1406 or Portable oxygen equipment - E0431, E0433, E0434, E1392, or K0738),
- The HCPCS modifier RA (Replacement of a DME Item), and
- A narrative describing why the equipment was replaced. Note: Proof-of-delivery documentation from the previous supplier is not required.

In addition, the contractor must verify the following information is included and valid to support the supplier declared Chapter 7 or 11 bankruptcy under Title 11 of the United States Code bankruptcy and is unable to continue furnishing oxygen and oxygen equipment to patients:

A. For a Chapter 7 bankruptcy, supporting documentation must include court records documenting that the previous supplier filed a petition for a Chapter 7 bankruptcy in a United States Bankruptcy Court; and

B. For a Chapter 11 bankruptcy, supporting documentation must include court records documenting that the previous supplier filed a petition for a Chapter 11 bankruptcy in a United States Bankruptcy Court, and documents filed in the bankruptcy case confirming that the equipment was sold or is scheduled to be sold as evidenced by one of the following:
- The court order authorizing and/or approving the sale; or
- Supporting documentation that the sale is scheduled to occur or has occurred (e.g., a bill of sale, or an asset purchase agreement signed by the seller and the buyer); or
- A court order authorizing abandonment of the equipment.

Messages for Denied Claims
Contractors will deny claims for replacement oxygen equipment due to bankruptcy if verification of the above supporting documentation is unsuccessful.

When denying claims for replacement oxygen equipment due to insufficient supporting documentation, the following reason and remark codes and messages will be used:

- Group Code CO (Contractual Obligation),
- A1 - Claim/Service Denied,
- N225 - Incomplete/invalid documentation/orders/notes/summary/report/chart, and
- MSN 9.2 - This item or service was denied because information required to make payment was missing. (Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida).
**Note:** No payment will be made for replacement equipment when the original supplier divests business and equipment outside of the court bankruptcy process.

**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](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.


**New Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Specialty Code for Ocularists**

**MLN Matters® Number:** MM6891  
**Related Change Request (CR) #:** 6891  
**Related CR Release Date:** August 20, 2010  
**Effective Date:** April 1, 2011  
**Related CR Transmittal #:** R2030CP  
**Implementation Date:** April 4, 2011

**Provider Types Affected**

Suppliers and providers who bill Medicare Carriers, Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for ocular services to Medicare beneficiaries are affected by this change.

**Provider Action Needed**

This article is based on Change Request (CR) 6891 that instructs Ocularists to use the new DMEPOS specialty code B5 as a valid primary and/or secondary specialty code.

**Background**

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6891 to reflect the establishment of the new DMEPOS specialty code for Ocularists which is B5. Specialty codes are used by CMS for programmatic and claims processing purposes. They are used in expenditure analysis, and Medicare contractors use specialty code data to develop claims processing edits.

**Additional Information**

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

The official instruction, CR6891, issued to your Medicare A/B MAC, DME MAC or carrier regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R2030CP.pdf](http://www.cms.gov/Transmittals/downloads/R2030CP.pdf) on the CMS website.

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

**MLN Matters® Number:** MM7064  
**Related Change Request (CR) #:** 7064  
**Related CR Release Date:** August 20, 2010  
**Effective Date:** January 1, 2011  
**Related CR Transmittal #:** R2033CP  
**Implementation Date:** January 3, 2011

**Provider Types Affected**

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

**Provider Action Needed**

**STOP – Impact to You**

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

**CAUTION – What You Need to Know**

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

**GO – What You Need to Do**

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

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

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

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

Patient-level Adjustments

The patient-level adjustments are patient-specific case-mix adjusters that were developed from a two-equation regression analysis that encompasses composite rate and separately billable items and services. Included in the case-mix adjusters for adults are those variables that are currently used in basic case-mix adjusted composite payment system, that is, age, body surface area (BSA), and low body mass index (BMI). In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six co-morbidity categories and an adjustment for the onset of renal dialysis.

Outlier Adjustment

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

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

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and

Facility-level Adjustments

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

Training Add-On

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

Adjustments Specific to Pediatric Patients

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

Treatments furnished to pediatric patients:

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

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

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

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Blended Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>75 percent of the old payment methodology, and 25 percent of new PPS payment</td>
</tr>
<tr>
<td>2012</td>
<td>50 percent of the old payment methodology, and 50 percent of the new PPS payment</td>
</tr>
<tr>
<td>2013</td>
<td>25 percent of the old payment methodology, and 75 percent of the new PPS payment</td>
</tr>
<tr>
<td>2014</td>
<td>100 percent of the PPS payment</td>
</tr>
</tbody>
</table>

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.
For Calendar Year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

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

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

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

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

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

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

The ESRD PRICER will provide the payment for existing composite rate portion of the blended payment amount. CMS updated the composite rate portion of the blended payment amount. CMS.

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

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

**Three New Adjustments Applicable to the Adult Rate**

1. **Comorbid Adjustments:** The new ESRD PPS provides for 3 categories of chronic comorbid conditions and 3 categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The 3 chronic comorbid categories eligible for a payment adjustment are:

- Hereditary hemolytic and sickle cell anemia;
- Monoclonal gammopathy (in the absence of multiple myeloma); and
- Myelodysplastic syndrome.

The 3 acute comorbid categories eligible for a payment adjustment are:

- Bacterial Pneumonia;
- Gastrointestinal Bleeding; and
- Pericarditis.

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

3. **Low-Volume Facility Adjustment:** Providers will receive an adjustment to their ESRD PPS rate when the facility furnished less than 4,000 treatments in each of the three years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three (3) years preceding the payment year. The 3 years preceding treatment data should be reflected on the last 2 settled cost reports and the most recent must be filed. The provider must notify their Medicare Contractor if they believe they are eligible for the low-volume adjustment.

**Change in Processing Home Dialysis Claims**

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

**Consolidated Billing**

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

Other Billing Reminders

- Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.
- Medicare will return claims to the provider with dates of service spanning 2010 and 2011.
- Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.
- When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC NS38 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.), and assign Group code CO.
- All 72X claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.

Additional Information

The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2033CP.pdf on the CMS website. Attached to CR 7064, you may find the following documents to be helpful:

- Attachment 3, which is a list of outlier services;
- Attachment 4, which is a list of DME ESRD Supply HCPCS codes used in for ESRD PPS consolidated billing edits;
- Attachment 5, which contains a list of DME ESRD Supply HCPCS codes that are NOT payable to DME suppliers;
- Attachment 6, which is a list of laboratory CPT/HCPCS codes subject to ESRD consolidated billing;
- Attachment 7, which lists the drug codes subject to ESRD consolidated billing; and
- Attachment 8, which lists by ICD-9-CM codes, the comorbid categories and diagnosis codes.

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

Electronic Data Interchange (EDI)

Implementation of the PWK (Paperwork) Segment for X12N Version 5010

MLN Matters® Number: MM7041
Related Change Request (CR) #: 7041
Related CR Release Date: August 27, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R763OTN
Implementation Date: April 4, 2011

Provider Types Affected

This article is for physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors, and fiscal intermediaries (FIs) including regional home health intermediaries).

Provider Action Needed

This article is based on Change Request (CR) 7041 which announces the implementation of the PWK (paperwork) segment for X12N Version 5010. Be sure your billing staff is aware of these changes.

Background

Since 2003, the Centers for Medicare & Medicaid Services (CMS) has believed that a complete Health Insurance Portability & Accountability Act of 1996 (HIPAA) implementation involves implementing the PWK (paperwork) segment. The PWK is a segment within the 837 Professional and Institutional electronic transactions. The PWK segment provides the “linkage” between electronic claims and additional documentation which is needed
for claims adjudication. Although the PWK segment allows for an electronic submission of the additional documentation, this preliminary implementation will only allow for submission of additional documentation via mail and fax.

The implementation of a dedicated PWK process, involving OCR/imaging technology, allows providers to continue using cost effective electronic data interchange (EDI) technology as well as providing cost savings for the Medicare program. Medicare contractors will be responsible for imaging, storage, and retrieval of the additional documentation for their claims examiners. Having the documentation available to claims examiners eliminates the need for costly automated development.

Key Points for Medicare Billers:

- Your Medicare contractor will implement the appropriate PWK fax/mail cover sheet for their line of business which must be used by trading partners when mailing or faxing additional documentation which is indicated in the PWK segment. Sample versions of the fax/mail cover sheets are attached to CR 7041, which is available at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS website.
- Your Medicare contractor will provide the cover sheet to their trading partners via hardcopy and/or electronic download.
- Submitters must send the additional documentation AFTER the claim has been electronically submitted with the PWK segment.
- Submitters will need to accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- Medicare contractors will manually return PWK data submissions (cover sheet and attached data) which are incomplete or incorrectly filled out.
- Medicare contractors will allow seven calendar “waiting” days (from the date of receipt) for additional information to be faxed or ten calendar “waiting” days for additional information to be mailed.
- Submitters must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days (fax) or ten calendar waiting days for mailed submissions, your contractor will begin normal processing procedures on your claim.
- Medicare will not crossover PWK data to the Coordination of Benefits contractor.

Additional Information

If you have questions, please contact your Medicare MAC and/or FI/carrier at their toll-free number which may be found at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS website.

The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS website.

**Miscellaneous**

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

**MLN Matters Number:** MM7006 Revised  
**Related Change Request (CR) #:** 7006  
**Related CR Release Date:** August 4, 2010  
**Effective Date:** October 1, 2010  
**Related CR Transmittal #:** R2017CP  
**Implementation Date:** October 4, 2010

**Note:** This article was revised on August 4, 2010, to reflect the revised CR 7006, which was revised on August 4. In this article, the CR release date and Transmittal number (see above) were changed and the Web address for accessing CR 7006 was also changed. All other information is the same.

**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/R2017CP.pdf](http://www.cms.gov/Transmittals/downloads/R2017CP.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](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

**Discarded Drugs and Biologicals Policy at Contractor Discretion**

**MLN Matters® Number:** MM7095  
**Related Change Request (CR) #:** 7095  
**Related CR Release Date:** August 20, 2010  
**Effective Date:** July 30, 2010  
**Related CR Transmittal #:** R758OTN  
**Implementation Date:** September 21, 2010

**Provider Types Affected**
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs) and/or durable medical equipment (DME) MACs) for drugs or biologicals administered to Medicare beneficiaries.

**Provider Action Needed**

**STOP – Impact to You**
This article is based on Change Request (CR) 7095 which is being issued in response to inquiries related to CR 6711 pertaining to the use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs and biologicals.

**CAUTION – What You Need to Know**
CR 7095 instructs that each Medicare contractor 1) has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and 2) will notify their respective providers of such requirements associated with the use of the JW modifier.

**GO – What You Need to Do**
Your Medicare contractor will provide you with details concerning the use of the JW modifier for discarded drugs and biological. Be sure to follow those requirements.

**Background**
Previously, the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6711 (see the MLN Matters® article related to CR 6711 at [http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf](http://www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf) on the CMS website) which updated the Medicare Claims Processing Manual (Chapter 17, Section 40) and provided policy on the appropriate use of the JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs or biologicals. After issuing CR 6711, CMS received several inquiries from various providers regarding how the JW modifier is to be used for their Medicare Part B drug claims.

CR 7095 is being issued in response to these inquiries, and it instructs that each Medicare contractor:

- Has the individual discretion to determine whether the JW modifier is required for any claims with discarded drugs including the specific details regarding how the discarded drug information should be documented and applied on the claim; and
- Will notify their respective providers of such requirements associated with the use of the JW modifier.

**Additional Information**
The official instruction, CR 7095, issued to your carrier, FI, A/B MAC, or DME MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R758OTN.pdf](http://www.cms.gov/Transmittals/downloads/R758OTN.pdf) on the CMS website.

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

**Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services**

**Related Change Request (CR) #:** N/A  
**Revised MLN Matters Number:** SE0432  
**Effective Date:** N/A  
**Implementation Date:** N/A

**Note:** This article was revised on July 22, 2010, to include “ambulatory surgical centers” in the last sentence in the top paragraph of page 3. All other information remains the same.

**Provider Types Affected**
Skilled Nursing Facilities (SNFs), physicians, suppliers, providers, and imaging centers.
Clariﬁcation: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are speciﬁcally excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare Intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier (DMERC).

Provider Action Needed
This Special Edition describes SNF Consolidated Billing (CB) as it relates to certain types of exceptionally intensive outpatient hospital services, such as Magnetic Resonance Imaging (MRI) services, Computerized Axial Tomography (CT) Scans, and Radiation Therapy.

Background
When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid, but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF’s residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are speciﬁcally excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. For a detailed overview of SNF CB, including a section on services excluded from SNF CB, see MLN Matters Special Edition article SE0431 at http://www.cms.gov/MLNMattersArticles/downloads/se0431.pdf on the CMS website.

The original CB legislation (Section 4432(b) of the Balanced Budget Act of 1997, P.L. 105-33 (BBA 1997)) speciﬁed a list of services at Section 1888(e)(2)(A)(ii) of the Social Security Act that were excluded from this provision. As with the inpatient hospital bundling requirement (Section 1862(a)(14) of the Social Security Act) on which it was modeled, the SNF CB provision excluded primarily the services of physicians and certain other practitioners.

Moreover, these services were excluded categorically, without regard to the speciﬁc setting in which they were furnished. This legislation did not authorize the Department of Health and Human Services (DHHS) to create additional categorial exclusions from CB administratively, thereby reserving this authority for the Congress itself. In fact, the Congress subsequently did enact a number of additional CB exclusions that applied uniformly to services furnished in both hospital and non-hospital settings, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA 1999, P.L.106-113, Appendix F).

While the original CB legislation did not authorize DHHS to simply carve out entire categories of services from CB without regard to setting, it did deﬁne the SNF CB provision in terms of services furnished to a resident of a SNF, and provided a degree of administrative discretion in defining when a beneficiary is considered to be a SNF “resident” for this purpose.

Using this authority, the Centers for Medicare & Medicaid Services (CMS) identiﬁed several types of exceptionally intensive outpatient hospital services that were well beyond the general scope of SNF care plans. These services include:

- Emergency services;
- Cardiac catheterizations;
- Computerized Axial Tomography (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory surgery;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

CMS established that a beneﬁciary’s receipt of such services in the outpatient hospital setting had the effect of temporarily suspending his/her status as a SNF resident for CB purposes, thus enabling the hospital to bill Part B separately for the services. (See Title 42 of the Code of Federal Regulations (42 CFR), Section 411.15(p) (3)(iii)). The underlying rationale for this exclusion was that these services were so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.

In the legislative history that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), Congress explicitly recognized that this administrative exclusion is speciﬁcally limited to “…certain outpatient services from a Medicare participating hospital or critical access hospital…” (emphasis added), (See the House Ways and Means Committee Report (H. Rep. No. 108-178, Part 2 at 209), and the Conference Report (H. Conf. Rep. No. 108-391 at 641)). This means that the exclusion does not encompass services that are furnished in other, non-hospital settings (such as freestanding clinics or ambulatory surgical centers).

As noted previously, in addition to the existing exclusion of certain types of intensive outpatient hospital services under the regulations at 42 CFR 411.15(p)(3)(iii), Congress has elected to exclude several categories of services from CB in the statute itself, at Sections 1888(e)(2)(A)(ii)-(iii) of the Social Security Act. Unlike the administrative exclusion discussed above, which applies solely to services furnished in the outpatient hospital setting, the statutorily excluded services are separately billable to Part B regardless of the setting (hospital versus freestanding) in which they are furnished.

For example, as amended by Section 103 of BBRA 1999, Section 1888(e)(2)(A)(iii)(I) of the Social Security Act excludes certain types of intensive chemotherapy services, regardless of whether they are furnished in a hospital or freestanding setting. Additional legislation would be required to expand the exemption of CT scans, MRI services, and radiation therapy to apply to services furnished in non-hospital settings.
Chemotherapy and its administration and radioisotopes and their administration are identified in the statute by HCPCS Code. These services are separately billable in all care settings, but the exclusion applies only to the codes specified in the Social Security Act and subsequent regulations. Therefore, other services given in conjunction with an excluded code (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

Please note that the professional charge for the physician who performs/interprets the radiological procedure is NOT subject to CB. Since the physician service exclusion applies to the professional component of the diagnostic radiology service, the physician bills his/her service directly to the Medicare Part B carrier for reimbursement.

Additional Information
See MLN Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at http://www.cms.gov/MLNMattersArticles/downloads/se0431.pdf on the CMS website.

The Centers for Medicare and Medicaid Services (CMS) MLN Consolidated Billing Website can be found at http://www.cms.gov/SNFConsolidatedBilling/ on the CMS website.

It includes the following relevant information:
- General SNF CB information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and

Medical Record Retention and Media Formats for Medical Records

Medical Record Retention and Media Formats for Medical Records

GO – What You Need to Do
Review the information in this article and ensure that you are in compliance. Be sure to inform your staff.

Retention Periods
State laws generally govern how long medical records are to be retained. However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA) administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt State laws if they require shorter periods. Your State may require a longer retention period. The HIPAA requirements are available at 45 CFR 164.316(b) (2) (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl) on the Internet.

While the HIPAA Privacy Rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. The Privacy Rule is available at 45 CFR 164.530(c) (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr164_main_02.tpl) on the Internet.

The Centers for Medicare & Medicaid Services (CMS) requires records of providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report. This requirement is available at 42 CFR 482.404(b)(1) (http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr482_05.html) on the Internet.

CMS requires Medicare managed care program providers to retain records for 10 years. This requirement is available at 42 CFR 422.504[d][2][iii] (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=ab240bf0e5f6388a75cbe07cc5cf1d21r&rgn=div5view=text;node=42%3A3.0.1.19;idno=42;cc=ecfr) on the Internet.

Provider Types Affected
This is an informational article for physicians, non-physician practitioners, suppliers, and providers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You
This Special Edition is informational in nature. There are no additions or changes to current policies and procedures.
by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Providers may want to obtain legal advice concerning record retention after these time periods and medical document format.

Additional Information

CMS is currently engaged in a multi-year project to offer incentives to eligible providers that meaningfully use certified electronic health records (EHRs). In close coordination with this incentive program, the Office of the National Coordinator for Health IT (ONC) has developed the initial set of standards and certification requirements for EHRs in order to promote health information exchange and interoperability. You may be eligible to receive incentive payments to assist in implementing certified EHR technology systems.

Use of “certified EHR technology” is a core requirement for physicians and other providers who seek to qualify to receive incentive payments under the Medicare and Medicaid Electronic Health Record Incentive Programs provisions authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009.

Additional information about this initiative may be found at http://www.cms.gov/EHRIncentivePrograms/ on the CMS website.

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

Provisions in the Affordable Care Act of 2010 (ACA)

MLN Matters® Number: SE1023
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

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 GPCLs 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 GPCLs 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.

Important News About Flu Shot Frequency for Medicare Beneficiaries
MLN Matters Number: SE1026
Related CR Transmittal #: N/A
Effective Date: N/A
Provider Types Affected
This article is for physicians, providers, and suppliers providing flu shot services to Medicare beneficiaries.

What You Need to Know
This article provides important information to physicians and other providers regarding the frequency of allowable flu vaccinations for Medicare beneficiaries.

Background
Effective for services furnished on or after May 1, 1993, the Medicare Part B program covers influenza virus vaccine and its administration when furnished in compliance with any applicable State law by any provider of services or any entity enrolled in the Medicare program. Typically, one vaccine is allowable per influenza virus season (once a year in the fall or winter). Medicare will pay for more than one influenza virus vaccination per influenza season if a physician determines and documents in the patient’s medical record that the additional vaccination is reasonable and medically necessary. Medicare beneficiaries may receive the vaccine once each influenza season, paid by Medicare, without a physician’s order and without the supervision of a physician. A patient could receive an influenza virus vaccine twice in a calendar year and Medicare will pay for.

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.
both. For example, a beneficiary may receive an influenza virus vaccination in January 2010 and another influenza virus vaccination in November 2010.

**Medicare Billing for Flu Vaccines**

Because Medicare beneficiaries generally fall into a high-risk category, they are being encouraged to obtain the flu vaccine every flu season. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, for Medicare payment of the vaccine and its administration, beneficiaries should obtain their vaccinations from a Medicare-enrolled physician/provider.

If you are a Medicare-enrolled physician or provider (including centralized billers) and have the flu vaccine available, you must bill Medicare for the cost of the vaccination and its administration. Medicare beneficiaries do not pay any deductible or coinsurance. Please remember that Medicare allows for roster billing when you administer the flu vaccine to a number of beneficiaries at one location (e.g., a physician’s office).

**Additional Information**


If you do not have the vaccine available, you should refer your patients to 1.800.MEDICARE (1.800.633-4227; TTY users should call 1.877.486.2048) or to [http://www.medicare.gov](http://www.medicare.gov) where they can get the phone number for their state health department. Health departments throughout the United States are attempting to ensure that as many high-risk individuals as possible will get a flu vaccine.

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**Claims**

**Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted or Terminated**

- **MLN Matters® Number:** MM6625
- **Related Change Request (CR) #:** 6625
- **Related CR Release Date:** July 30, 2010
- **Effective Date:** April 1, 2011
- **Related CR Transmittal #:** R2014CP
- **Implementation Date:** April 4, 2011

**Provider Types Affected**

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Contractors (DME MAC) for services provided, or supplied, to Medicare beneficiaries.

**What You Need to Know**

CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACS, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen Group Health Plan (GHP) Medicare Secondary Payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates this burden. As a result of CR 6625, Medicare will implement an automated process to:

1. Reopen certain MSP claims when certain MSP records are deleted, or
2. Under some circumstances when certain MSP records are terminated and claims are denied due to MSP or Medicare
made a secondary payment before the termination date is accreted.

Basically, where Medicare learns, retroactively, that Medicare Secondary Payer data for a beneficiary is no longer applicable, Medicare will require its systems to search claims history for claims with dates of service within 180 days of a MSP GHP deletion date or the date the MSP GHP termination was applied, which were processed for secondary payment or were denied (rejected for Part A only claims). If claims were processed, the Medicare contractors will reprocess them in view of the more current MSP GHP information and make any claims adjustments that are appropriate. If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional Information

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

Claim Status Category and Claim Status Code Update
MLN Matters® Number: MM7052
Related Change Request (CR) #: 7052
Related CR Release Date: July 16, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R2002CP
Implementation Date: October 4, 2010

Provider Types Affected
All physicians, providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Part 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 CR7052, 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 along with the 277 Health Care Claim Acknowledgement were updated during the June 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 or about July 1, 2010. 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 October 4, 2010. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background
The Health Insurance Portability and Accountability Act 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 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. 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 CMS website.

The official instruction, (CR7052), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2002CP.pdf on the CMS website.

Timely Claims Filing: Additional Instructions
MLN Matters® Number: MM7080
Related Change Request (CR) #: 7080
Related CR Release Date: July 30, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R734OTN
Implementation Date: January 3, 2011

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) issued Change Request (CR) 7080 to expand the Medicare Fee-for-Service (FFS) reimbursement instructions outlined in change request (CR) 6960 that specified the basic timely filing standards established for FFS reimbursement. Those basic standards are a result of Section 6404 of the Patient Protection and Affordable Care Act of 2010 (ACA) that states that claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service...
Background

CMS is addressing institutional claims and professional/supplier claims differently with respect to span date claims. Institutions often bill for extended lengths of stays that exceed a month's (or more) duration. Therefore, it is both less burdensome and more reasonable to use the claim's “Through” date rather than the “From” date as the date of service for determining claims filing timeliness.

Conversely, for physicians and other suppliers that bill claims with span dates, these span date services cannot exceed one month. Thus, there is no compelling need to create an extended filing period. CMS also notes that, if the “From” date of these span date services is timely, then those services billed within the span are timely as well, and this will generally ease the administrative burden of the claims processing contractors in their determination of timely filed claims. Therefore, the “From” date standard will be used for determining claims filing timeliness for physicians and other suppliers that bill claims with span date services. With respect to supplies and rental items, they are physically furnished at or near the beginning of the span dates on the claim. Therefore, the “From” date standard reflects more precisely when the supply or item was delivered to the beneficiary, and will be used as the date for determining claims filing timeliness.

Key Points of CR 7080:

- For institutional claims that include span dates of service (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim will be used to determine the date of service for claims filing timeliness.
- For professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers that include span dates of service, the line item “From” date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).
- BE AWARE: If a line item “From” date is not timely, but the “To” date is timely, Medicare contractors will split the line item and deny untimely services as not timely filed.
- Claims having a date of service of February 29th must be filed by February 28th of the following year to be considered as timely filed. If the date of service is February 29th of any year and is received on or after March 1st of the following year, the claim will be denied as having failed to meet the timely filing requirement.

Additional Information

Remember CR6960 established that Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

You can find the official instruction, CR7080, issued to your carrier, FI, A/B MAC, or RHHI by visiting http://www.cms.gov/Transmittals/downloads/R734OTN.pdf on the CMS website. If you have any questions, please contact your FI, MAC, or RHHI at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

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

MLN Matters® Number: MM7089
Related Change Request (CR) #: 7089
Related CR Release Date: August 6, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R2019CP
Implementation Date: October 4, 2010

Provider Types Affected

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

Provider Action Needed

CR 7089, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective October 1, 2010 for Medicare. These are the changes that have been added since CR 6901. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month.
The CARC list is maintained by the Claim Adjustment Status Code Maintenance Committee, and used by all payers. This committee meets 3 times a year, and this code list also gets updated 3 times a year – in early March, July and November. Both code lists are posted at [http://www.wpc-edi.com/Codes](http://www.wpc-edi.com/Codes) on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 7089.

**Additional Information**


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

### New Codes - CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date Per WPC Posting</th>
</tr>
</thead>
<tbody>
<tr>
<td>235</td>
<td>Sales Tax.</td>
<td>06/06/2010</td>
</tr>
</tbody>
</table>

### Modified Codes - CARC

None.

### Deactivated Codes - CARC

None.

### New Codes - CARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Medicare Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>N533</td>
<td>Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.</td>
<td>NO</td>
</tr>
<tr>
<td>N534</td>
<td>This is an individual policy; the employer does not participate in plan sponsorship.</td>
<td>NO</td>
</tr>
<tr>
<td>N535</td>
<td>Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.</td>
<td>YES</td>
</tr>
<tr>
<td>N536</td>
<td>We are not changing the prior payer’s determination of patient responsibility, which you may collect, as this service is not covered by us.</td>
<td>NO</td>
</tr>
<tr>
<td>N537</td>
<td>We have examined claims history and no records of the services have been found.</td>
<td>NO</td>
</tr>
<tr>
<td>N538</td>
<td>A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.</td>
<td>NO</td>
</tr>
<tr>
<td>N539</td>
<td>Alert: We processed appeals/waiver requests on your behalf and that request has been denied.</td>
<td>NO</td>
</tr>
</tbody>
</table>

### Modified Codes - RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Medicare Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>N115</td>
<td>This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <a href="http://www.cms.gov/mcd">www.cms.gov/mcd</a>, or if you do not have web access, you may contact the contractor to request a copy of the LCD.</td>
<td>YES</td>
</tr>
<tr>
<td>N386</td>
<td>This decision was based on National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is required. A copy of this policy is available at <a href="http://www.cms.gov/mcd/search.asp">http://www.cms.gov/mcd/search.asp</a>. If you do not have web access, you may contact the contractor to request a copy of the NCD.</td>
<td>YES</td>
</tr>
<tr>
<td>N528</td>
<td>Patient is entitled to benefits for Institutional Services only.</td>
<td>NO</td>
</tr>
<tr>
<td>N529</td>
<td>Patient is entitled to benefits for Professional Services only.</td>
<td>NO</td>
</tr>
<tr>
<td>N530</td>
<td>Not Qualified for Recovery based on enrollment information.</td>
<td>NO</td>
</tr>
</tbody>
</table>

### Deactivated Codes - RARC

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>M118</td>
<td>Letter to follow containing further information.</td>
<td>Consider using N202</td>
</tr>
<tr>
<td>MA101</td>
<td>A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.</td>
<td>Consider using N538</td>
</tr>
<tr>
<td>N201</td>
<td>A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.</td>
<td>Consider using N538</td>
</tr>
<tr>
<td>NS14</td>
<td>Consult plan benefit documents/guidelines for information about restrictions for this service.</td>
<td>Consider using N130</td>
</tr>
</tbody>
</table>

### Claim Status Category and Claim Status Codes Update

**MLN Matters® Number:** MM7158  
**Related Change Request (CR) #:** 7158  
**Related CR Release Date:** September 17, 2010  
**Effective Date:** January 1, 2011  
**Related CR Transmittal #:** R2049CP  
**Implementation Date:** January 3, 2011

#### Provider Types Affected

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

#### Provider Action Needed

This article, based on CR 7158, 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 along with the 277 Health Care Claim Acknowledgement updated during the October 2010 meeting of the national Code Maintenance Committee and code changes approved at that
meeting are to be posted at http://www.wpc-edi.com/content/view/180/223/ on or about November 1, 2010. 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 January 3, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

**Background**
The Health Insurance Portability and Accountability Act 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 and 005010X212). The Centers for Medicare & Medicaid Services (CMS) has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. 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 CMS website.

The official instruction, (CR 7158), issued to your Medicare contractor regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2049CP.pdf on the CMS website.

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**Fees & ASP Pricing**

**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

**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 necessary 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](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) 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 (RHIIs)) 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:

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2010 ASP and ASP NOC files</td>
<td>October 1, 2010, through December 31, 2010</td>
</tr>
<tr>
<td>July 2010 ASP and ASP NOC files</td>
<td>July 1, 2010, through September 30, 2010</td>
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<td>April 2010 ASP and ASP NOC files</td>
<td>April 1, 2010, through June 30, 2010</td>
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<td>January 2010 ASP and ASP NOC files</td>
<td>January 1, 2010, through March 31, 2010</td>
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<tr>
<td>October 2009 ASP and ASP NOC files</td>
<td>October 1, 2009, through December 31, 2009</td>
</tr>
</tbody>
</table>

**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](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.


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

**MLN Matters® Number:** MM7070  
**Related Change Request (CR) #:** 7070  
**Related CR Release Date:** July 23, 2010  
**Effective Date:** January 1, 2010 for codes in effect then, October 1, 2010 for other changes  
**Related CR Transmittal #:** R2006CP  
**Implementation Date:** October 4, 2010

**Provider Types Affected**

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 items or services paid under the DMEPOS fee schedule need to be aware of this article.

**Provider Action Needed**

This article is based on CR 7070, which provides the required quarterly update of the 2010 DMEPOS Fee Schedule. Be sure billing staffs are aware of the update.

**Background**

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the Medicare Claims Processing Manual, Chapter 23, Section 60 at [https://www.cms.gov/manuals/downloads/clm104c23.pdf](https://www.cms.gov/manuals/downloads/clm104c23.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.

**Key Points of CR7070**

- Per Transmittal 686 (Change Request 6743), the claims filing jurisdiction for HCPCS code L8509 (Tracheo-Esophageal Voice Prosthesis, Inserted by a Licensed Health Care Provider, Any Type) is changing from the DME MACs to the A/B MACs/Part B carriers, effective October 1, 2010. To reflect this change, the claims jurisdiction for code L8509 will change in the DMEPOS fee schedule file to local carrier as part of this update.
- As part of this update, the Alaska and Hawaii fee schedule amounts for HCPCS code E0973 (Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each) are being revised in order to correct errors made in the calculation of the fee schedule amounts. Medicare contractors will adjust previously processed claims for code E0973 with dates of service on or after January 1, 2010, if they are resubmitted as adjustments.
### Additional Information


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


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### HCPCS


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<th>MLN Matters® Number: MM7110</th>
<th>Related Change Request (CR) #: 7110</th>
<th>Related CR Release Date: September 17, 2010</th>
<th>Effective Date: December 22, 2010</th>
<th>Related CR Transmittal #: R2056CP</th>
<th>Implementation Date: December 22, 2010</th>
</tr>
</thead>
</table>

#### Provider Types Affected

Suppliers submitting claims to Medicare Contractors (DME Medicare Administrative Contractors (DME MACs), Part B carriers, and Medicare Administrative Contractors (A/B MAC)) for DMEPOS services provided to Medicare beneficiaries are affected.

#### Provider Action Needed

This article is informational and based on Change Request (CR) 7110 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2010 Jurisdiction List is an Excel® spreadsheet and is available at [http://www.cms.gov/Center/dme.asp](http://www.cms.gov/Center/dme.asp) on the Centers for Medicare & Medicaid Services (CMS) website.

#### HCPCS Description and Jurisdiction

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<td>A4206 - A4209</td>
<td>Medical, Surgical, and Self-Administered Injection Supplies</td>
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</tr>
<tr>
<td>10</td>
<td>A4211</td>
<td>Medical, Surgical, and Self-Administered Injection Supplies</td>
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<tr>
<td>13</td>
<td>A4212</td>
<td>Non Coring Needle or Stylet with or without Catheter</td>
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<td>Medical, Surgical, and Self-Administered Injection Supplies</td>
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<td>A4221 - A4250</td>
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<td>34</td>
<td>A4266 - A4269</td>
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</table>
### DME MAC Jurisdiction C

#### INSIDER

**Edition 14 · Winter 2011**

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## A B C

### 1

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<th>JURISDICTION</th>
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<td>36 A4280</td>
<td>Accessory for Breast Prosthesis</td>
<td>DME MAC</td>
</tr>
<tr>
<td>37 A4281 - A4286</td>
<td>Accessory for Breast Pump</td>
<td>DME MAC</td>
</tr>
<tr>
<td>38 A4290</td>
<td>Sacral Nerve Stimulation Test Lead</td>
<td>Local Carrier</td>
</tr>
<tr>
<td>39 A4300 - A4301</td>
<td>Implantable Catheter</td>
<td>Local Carrier</td>
</tr>
<tr>
<td>40 A4305 - A4306</td>
<td>Disposable Drug Delivery System</td>
<td>Local Carrier if incident to a physician’s service (not separately payable). If other DME MAC.</td>
</tr>
<tr>
<td>41 A4310 - A4358</td>
<td>Incontinence Supplies/Urinary Supplies</td>
<td>If provided in the physician’s office for a temporary condition, the item is incident to the physician’s service &amp; billed to the Local Carrier. If provided in the physician’s office or other place of service for a permanent condition, the item is a prosthetic device &amp; billed to the DME MAC.</td>
</tr>
<tr>
<td>42 A4360 - A4434</td>
<td>Urinary Supplies</td>
<td>If provided in the physician’s office for a temporary condition, the item is incident to the physician’s service &amp; billed to the Local Carrier. If provided in the physician’s office or other place of service for a permanent condition, the item is a prosthetic device &amp; billed to the DME MAC.</td>
</tr>
<tr>
<td>43 A4450 - A4456</td>
<td>Tape; Adhesive Remover</td>
<td>Local Carrier if incident to a physician’s service (not separately payable). If other DME MAC.</td>
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<tr>
<td>44 A4458</td>
<td>Enema Bag</td>
<td>DME MAC</td>
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<tr>
<td>45 A4461-A4463</td>
<td>Surgical Dressing Holders</td>
<td>Local Carrier if incident to a physician’s service (not separately payable). If other DME MAC.</td>
</tr>
<tr>
<td>46 A4465 - A4466</td>
<td>Non-elastic Binder and Elastic Garment</td>
<td>DME MAC</td>
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<td>47 A4470</td>
<td>Gravlee Jet Washer</td>
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<tr>
<td>48 A4480</td>
<td>Valbra Aspirator</td>
<td>Local Carrier</td>
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<td>49 A4481</td>
<td>Tracheostomy Supply</td>
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<td>50 A4483</td>
<td>Moisture Exchanger</td>
<td>DME MAC</td>
</tr>
<tr>
<td>51 A4490 - A4510</td>
<td>Surgical Stockings</td>
<td>DME MAC</td>
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<tr>
<td>52 A4520</td>
<td>Diapers</td>
<td>DME MAC</td>
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### 2

**NOTE:** Deleted codes are valid for dates of service on or before the date of deletion.

**NOTE:** Updated codes are in bold.

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## A B C

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<tr>
<td>72 A4550</td>
<td>Surgical Trays</td>
<td>Local Carrier</td>
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<tr>
<td>73 A4554</td>
<td>Disposable Underpads</td>
<td>DME MAC</td>
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<tr>
<td>74 A4556 - A4558</td>
<td>Electrodes; Lead Wires; Conductive Paste</td>
<td>Local Carrier if incident to a physician’s service (not separately payable). If other DME MAC.</td>
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<td>75 A4559</td>
<td>Coupling Gel</td>
<td>Local Carrier if incident to a physician’s service (not separately payable). If other DME MAC.</td>
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<td>78 A4561 - A4562</td>
<td>Pessary</td>
<td>Local Carrier</td>
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<tr>
<td>80 A4565</td>
<td>Sling</td>
<td>Local Carrier</td>
</tr>
<tr>
<td>81 A4570</td>
<td>Splint</td>
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<tr>
<td>82 A4575</td>
<td>Topical Hyperbaric Oxygen Chamber, Disposable</td>
<td>DME MAC</td>
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<td>83 A4580 - A4590</td>
<td>Casting Supplies &amp; Material</td>
<td>Local Carrier</td>
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<td>85 A4595</td>
<td>TENS Supplies</td>
<td>Local Carrier if incident to a physician’s service (not separately payable). If other DME MAC.</td>
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<td>86 A4600</td>
<td>Sleeve for Intermittent Limb Compression Device</td>
<td>DME MAC</td>
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<td>89 A4601</td>
<td>Lithium Ion Battery for Non-Prosthetic Use</td>
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<td>92 A4604</td>
<td>Tubing for Positive Airway Pressure Device</td>
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<tr>
<td>94 A4605</td>
<td>Tracheal Suction Catheter</td>
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<td>95 A4606</td>
<td>Oxygen Probe for Oximeter</td>
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<td>Transtracheal Oxygen Catheter</td>
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<td>97 A4611 - A4613</td>
<td>Oxygen Equipment Batteries and Supplies</td>
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<td>Peak Flow Rate Meter</td>
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<td>107 A4646</td>
<td>Tissue Marker, Implanted</td>
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<tr>
<td>108 A4649</td>
<td>Miscellaneous Surgical Supplies</td>
<td>Local Carrier if incident to a physician’s service (not separately payable) or if supply for implanted prosthetic device or implanted DME. If other DME MAC..</td>
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<td>109 A4650</td>
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**NOTE:** Deleted codes are valid for dates of service on or before the date of deletion.

**NOTE:** Updated codes are in bold.
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343 | L7500 - L7520 | Repair of Prosthetic Device | Local Carrier if repair of implanted prosthetic device. If other, DME MAC.
344 | L7600 | Prosthetic Donning Sleeve | DME MAC
345 | L7900 | Vacuum Erection System | DME MAC
346 | L8000 - L8485 | Prosthetics | DME MAC
347 | L8499 | Unlisted Procedure for Miscellaneous Prosthetic Services | Local Carrier if implanted prosthetic device. If other, DME MAC.
348 | L8500 - L8501 | Artificial Larynx, Tracheostomy Speaking Valve | DME MAC
349 | L8505 | Artificial Larynx Accessory | DME MAC
350 | L8507 | Voice Prosthesis, Patient Inserted | DME MAC
351 | L8509 | Voice Prosthesis, Inserted by a Licensed Health Care Provider | Local Carrier for dates of service on or after 10/01/2010, DME MAC for dates of service prior to 10/01/2010.
352 | M0064 - M0301 | Medical Services | Local Carrier
353 | P2028 - P9615 | Laboratory Tests | Local Carrier
354 | Q0035 | Influenza Vaccine, Cardiokymography | Local Carrier
355 | Q0081 | Infusion Therapy | Local Carrier
356 | Q0083 - Q0085 | Chemotherapy Administration | Local Carrier
357 | Q0091 | Smear Preparation | Local Carrier
358 | Q0092 | Portable X-ray Setup | Local Carrier
359 | Q0111 - Q0115 | Miscellaneous Lab Services | Local Carrier
360 | Q0138-Q0139 | Feruoxymyl Injection | Local Carrier
361 | Q1044 | Azithromycin Dihydrate | Local Carrier if incident to a physician's service. If other, DME MAC.
362 | Q1063 - Q1081 | Anti-emetic | DME MAC
363 | Q1040 - Q1056 | Ventricular Assist Devices | Local Carrier
364 | Q0510 - Q0514 | Drug Dispensing Fees | DME MAC
365 | Q5015 | Sermorelin Acetate | Local Carrier
366 | Q1003 - Q1005 | New Technology IOL | Local Carrier
367 | Q2004 | Iridotomy Solution | Local Carrier
368 | Q2009 | Fosphenytoin | Local Carrier
369 | Q2017 | Teniposide | Local Carrier
370 | Q2025 | Oral Chemotherapy Drug (Effective July 1, 2010) | DME MAC

### A | B | C
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381 | Q0206-Q0207 | Injectable Dermal Fillers (Effective July 1, 2010) | Local Carrier
382 | Q3001 | Radio Elements for Brachytherapy | Local Carrier
383 | Q3014 | Telehealth Originating Site Facility Fee | Local Carrier
384 | Q3025 - Q3026 | Vaccines | Local Carrier
385 | Q3031 | Collagen Skin Test | Local Carrier
386 | Q4001 - Q4051 | Splints and Casts | Local Carrier
387 | Q4074 | Inhalation Drug | Local Carrier if incident to a physician's service. If other, DME MAC.
388 | Q4081 | Epoetin | DME MAC for method II home dialysis. If other, Local Carrier.
389 | Q4082 | Drug Subject to Competitive Acquisition Program | Local Carrier
390 | Q4100-Q4116 | Skin Substitutes | Local Carrier
391 | Q4083 - Q4085 | Chemotherapy Administration | Local Carrier
392 | Q4086 | Hydrophilic Contact Lenses | Local Carrier if incident to a physician's service. If other, DME MAC.
393 | Q4087 | Contact Lenses, Scleral | Local Carrier if incident to a physician's service. If other, DME MAC.
394 | Q2026-Q2027 | Injectable Dermal Fillers (Effective July 1, 2010) | Local Carrier
395 | Q2028-Q2029 | Ventricular Assist Devices | Local Carrier
396 | Q2030-Q2034 | Drug Dispensing Fees | DME MAC
397 | Q2035-Q2039 | Sermorelin Acetate | Local Carrier
398 | Q2040-Q2044 | New Technology IOL | Local Carrier
399 | Q2045-Q2049 | Iridotomy Solution | Local Carrier
400 | Q2050-Q2054 | Fosphenytoin | Local Carrier
401 | Q2055-Q2059 | Teniposide | Local Carrier
402 | Q2060-Q2064 | Oral Chemotherapy Drug (Effective July 1, 2010) | DME MAC
403 | Q2065-Q2069 | Skin Substitutes | Local Carrier
404 | Q2070-Q2074 | Ventricular Assist Devices | Local Carrier
405 | Q2075-Q2079 | Drug Dispensing Fees | DME MAC
406 | Q2080-Q2084 | Sermorelin Acetate | Local Carrier
407 | Q2085-Q2089 | New Technology IOL | Local Carrier
408 | Q2090-Q2094 | Iridotomy Solution | Local Carrier
409 | Q2095-Q2099 | Fosphenytoin | Local Carrier
410 | Q2100-Q2104 | Teniposide | Local Carrier
411 | Q2105-Q2109 | Oral Chemotherapy Drug (Effective July 1, 2010) | DME MAC
412 | Q2110-Q2114 | Skin Substitutes | Local Carrier
413 | Q2115-Q2119 | Ventricular Assist Devices | Local Carrier
414 | Q2120-Q2124 | Drug Dispensing Fees | DME MAC
415 | Q2125-Q2129 | Sermorelin Acetate | Local Carrier
416 | Q2130-Q2134 | New Technology IOL | Local Carrier
417 | Q2135-Q2139 | Iridotomy Solution | Local Carrier
418 | Q2140-Q2144 | Fosphenytoin | Local Carrier
419 | Q2145-Q2149 | Teniposide | Local Carrier
420 | Q2150-Q2154 | Oral Chemotherapy Drug (Effective July 1, 2010) | DME MAC
421 | Q2155-Q2159 | Skin Substitutes | Local Carrier
422 | Q2160-Q2164 | Ventricular Assist Devices | Local Carrier
423 | Q2165-Q2169 | Drug Dispensing Fees | DME MAC
424 | Q2170-Q2174 | Sermorelin Acetate | Local Carrier
425 | Q2175-Q2179 | New Technology IOL | Local Carrier
426 | Q2180-Q2184 | Iridotomy Solution | Local Carrier
427 | Q2185-Q2189 | Fosphenytoin | Local Carrier
428 | Q2190-Q2194 | Teniposide | Local Carrier
429 | Q2195-Q2199 | Oral Chemotherapy Drug (Effective July 1, 2010) | DME MAC
430 | Q2200-Q2204 | Skin Substitutes | Local Carrier
431 | Q2205-Q2209 | Ventricular Assist Devices | Local Carrier
432 | Q2210-Q2214 | Drug Dispensing Fees | DME MAC
433 | Q2215-Q2219 | Sermorelin Acetate | Local Carrier
434 | Q2220-Q2224 | New Technology IOL | Local Carrier
435 | Q2225-Q2229 | Iridotomy Solution | Local Carrier
436 | Q2230-Q2234 | Fosphenytoin | Local Carrier
437 | Q2235-Q2239 | Teniposide | Local Carrier
438 | Q2240-Q2244 | Oral Chemotherapy Drug (Effective July 1, 2010) | DME MAC

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**NOTE:** Deleted codes are valid for dates of service on or before the date of deletion.

**NOTE:** Updated codes are in bold.
Repair/Modification of Augmentative Communicative System or Device

MLN Matters® Number: MM7159
Related Change Request (CR) #: 7159
Related CR Release Date: September 10, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2048CP
Implementation Date: January 3, 2011PECOS

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered SNF stay.

Provider Action Needed

STOP – Impact to You
This article is based on Change Request (CR) 7159 which provides the 2011 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

CAUTION – What You Need to Know
Physicians and providers are advised that, by the first week in December 2010, new code files will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the Centers for Medicare & Medicaid Services (CMS) website. Note that this site will include new Excel® and PDF format files. It is important and necessary for the provider community to view the “General Explanation of the Major Categories” PDF file located at the bottom of each year’s FI/A/B MAC update listed at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS website in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

GO – What You Need to Do
See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Medicare’s claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the Medicare Claims Processing Manual (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at http://www.cms.gov/manuals/downloads/clm104c06.pdf on the CMS website. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information
The official instruction, CR 7159, issued to your carriers, DME MACs, FIs, and A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2048CP.pdf on the CMS website.

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

Competitive Bidding

Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception

MLN Matters® Number: MM6677 Revised
Related Change Request (CR) #: 6677
Related CR Release Date: November 6, 2009
Effective Date: April 1, 2010
Related CR Transmittal #: R590OTN
Implementation Date: April 5, 2010

Note: This article was revised on September 21, 2010 to remove a reference to the National Competitive Billing Indicator from the fourth bullet point in Key Points of CR6677 section. Providers are not responsible for coding that indicator. All other information remains the same.

Provider Types Affected
This article is for hospitals that bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for specific allowed competitively bid items (crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps) to their patients on the day of discharge.

What You Need To Know
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6677 to announce that hospitals may furnish certain competitively bid Durable Medical Equipment (DME) items to their patients on the date of discharge without submitting a bid and being awarded a contract under the Competitive Bidding Program.
Round 1 Rebid. The DME competitive bid items that a hospital may furnish upon discharge as part of this exception for Round 1 Rebid are walkers and related accessories. Note that this applies to claims received upon implementation of the DMEPOS Competitive Bidding Program Round One. That date is January 1, 2011, but the date is subject to change.

**Key Points of CR6677**

- Hospitals may furnish walkers and related accessories to their patients on the date of discharge whether or not the hospital has a contract under the DMEPOS Competitive Bidding Program.
- Separate payment is not made for walkers and related accessories furnished by a hospital on the date of admission as payment for these items is included in the Part A payment for inpatient facility services.
- Hospitals as defined below may furnish walkers and related accessories to their patients for use in the home on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier.
- To be paid for walkers and accessories as a non-contract supplier, hospitals should use the modifier “J4” on the claim line in combination with the following HCPCS codes: A4636, A4637, E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, E0149, E0154, E0155, E0156, E0157, E0158, and E0159.
- Hospital claims submitted for these items, for which Medicare does not find a matching date of discharge will be denied with remittance advice messages B15 (Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying service/procedure had not been received/adjudicated.), M114 (This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding these projects, contact your local contractor.), and MA13 (Alert: you may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.). Prior to denying these DME claims, Medicare will hold the claim for up to 15 business days to await the arrival of the hospital claim with the related discharge date. If such discharge is not processed by the end of the 15 business days, the DME claim will be denied.

**Background**

Section 302(b) (1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended section 1847 of the Social Security Act (the Act) to require the Secretary 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 Part B (the “Medicare DMEPOS Competitive Bidding Program”). On July 15, 2008, section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the MMA and mandated certain changes to the competitive bidding program. One of these changes established an exception for hospitals from the competitive bidding program when they are furnishing certain items to their own patients during an admission or on the date of discharge.

A hospital under this exception does not include a hospital-owned DME supplier. Instead, a hospital is defined in accordance with section 1861(e) of the Social Security Act. A DME supplier that furnishes the DME item to the hospital, which then furnishes the item to the patient on the date of discharge, must be a contract supplier in the competitive bidding program.

**Additional Information**

If you have questions, please contact your Medicare DME/MAC, FI or A/B MAC at their toll-free number which may be found at: [http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website. The official instruction (CR6677) issued to your Medicare FI, DME/MAC, or A/B MAC is available at [http://www.cms.gov/Transmittals/downloads/R590OTN.pdf](http://www.cms.gov/Transmittals/downloads/R590OTN.pdf) on the CMS website.

For discussion of the program instructions designating the competitive bidding areas and product categories included in the DMEPOS competitive bidding program round one rebid in CY 2009 you may review MM6571 at [http://www.cms.gov/MLNMattersArticles/downloads/MM6571.pdf](http://www.cms.gov/MLNMattersArticles/downloads/MM6571.pdf) on the CMS website.

The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round I rebid in 2009 can also be found at [http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp](http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp) on the CMS website. Further information on the boundaries and list of zip codes for each competitive bid area (CBA) and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting [http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp](http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp) and following the link to the Competitive Bidding Implementation Contractor (CBIC).
Durable Medical Equipment National Competitive Bidding Implementation — 10G: Paying for Oxygen Equipment When Grandfathered

MLN Matters® Number: MM6934
Related Change Request (CR) #: 6934
Related CR Release Date: June 10, 2010
Effective Date: October 1, 2010
Related CR Transmittal #: R718OTN
Implementation Date: October 4, 2010

Provider Types Affected
This article is for grandfathered suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen equipment furnished to Medicare beneficiaries after the start of a DMEPOS Competitive Bidding Program.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6934 to alert suppliers that a non-contract supplier who chose to be a grandfathered supplier for oxygen and oxygen equipment (i.e., portable or stationary) should also furnish additional oxygen equipment when medically necessary (i.e., portable or stationary) after the start of a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program to beneficiaries residing in a Competitive Bidding Area (CBA) who are already receiving oxygen equipment from the grandfathered supplier.

Key Points of CR6934
- If a beneficiary resides in a CBA, Medicare will pay claims for portable or stationary oxygen equipment that is acquired on or after the start of the Round One Rebid, at the single payment amount, when submitted by a grandfathered supplier, if the same supplier furnished stationary or portable oxygen equipment (grandfathered item), respectively, prior to the start of the Round One Rebid DMEPOS Competitive Bidding Program.
- If a beneficiary resides in a CBA, claims will be denied for portable or stationary oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the portable or stationary oxygen equipment prior to the start of the National Competitive Bid Round One Rebid (the portable or stationary oxygen equipment is not a grandfathered item).
- For oxygen equipment (stationary or portable) claims with dates of service on or after the start of the Round One Rebid, for a beneficiary residing in a CBA, claims will be denied when submitted by a grandfathered supplier, if the same grandfathered supplier did not furnish oxygen equipment (portable or stationary) prior to the start of the Round One Rebid (the items are not grandfathered).

Note: “Acquisition” in the context of CMS business rules means that the beneficiary’s oxygen Certificate of Medical Necessity (CMN) initial date is prior to the start date for the DMEPOS Competitive Bidding Program Round One Rebid.

Background
The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) amended section 1847 of the Social Security Act (the Act) requires the Secretary to establish and implement programs (the “Medicare DMEPOS Competitive Bidding Program”) under which 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.

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 CR6934, issued to your Medicare MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R718OTN.pdf on the CMS website.

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


The Centers for Medicare & Medicaid 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, including the latest EHR educational products. 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!

Vaccinate Early to Protect Against the Flu. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu viruses. Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. This year’s vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. Take advantage of each office visit and start protecting your patients as soon as your 2010-2011 seasonal flu vaccine arrives. And, don’t forget to immunize yourself and your staff. Get Your Flu Vaccine - Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare’s coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/AdultImmunizations on the CMS website.

CMS News Flash

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.

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 July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced two complementary final rules to implement the electronic health records (EHR) incentive program under the Health Information Technology for Economic and Clinical Health (HITECH) Act. Announcement of these regulations marks the completion of multiple steps laying the groundwork for the incentive payments program. To learn more about the Medicare and Medicaid EHR incentive programs, visit the CMS-dedicated website for this program at http://www.cms.gov/EHRIncentivePrograms/ on the CMS website.

The Centers for Medicare & Medicaid Services (CMS) has posted on its website 11 new frequently asked questions (FAQ) about the ICD-10 Implementation. To access these FAQs, please visit the CMS ICD-10 webpage at http://www.cms.gov/ICD10/; select the Medicare Fee-for-Service Provider Resources link 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.

Internet-based provider enrollment is easy and quick! Submit initial Medicare PECOS applications online up to 50% faster than on paper! Learn more at https://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website.

Remember: The Transition to ICD-10 is Coming October 1, 2013 – there will be no Extension. 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. For more information about ICD-10 Implementation, please read MLN Matters® Special Edition article SE1019 located at http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf 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 Centers for Medicare & Medicaid 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!

The Centers for Medicare & Medicaid Services (CMS) has posted on its website 11 new frequently asked questions (FAQ) about the ICD-10 Implementation. To access these FAQs, please visit the CMS ICD-10 webpage at http://www.cms.gov/ICD10/; select the Medicare Fee-for-Service Provider Resources link 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.

Providers, suppliers, physicians, and non-physician practitioners: Want more control over enrollment information? Internet-based PECOS does that. Learn more at https://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp on the CMS website.
# DME MAC Jurisdiction C Contact Information

<table>
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<tr>
<th>Contact for</th>
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<tr>
<td>EDI – Electronic Claim Submission;</td>
<td>Jurisdiction C CEDI (toll-free): 1.866.311.9184 (8:00a - 6:00p CST, Mon. – Fri.)</td>
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<tr>
<td></td>
<td>E-mail: <a href="mailto:ngs.CEDIHelpdesk@wellpoint.com">ngs.CEDIHelpdesk@wellpoint.com</a></td>
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<tr>
<td>Paper Claim Submission</td>
<td>Address: CIGNA Government Services</td>
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<tr>
<td></td>
<td>PO Box 20010, Nashville, TN 37202</td>
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<tr>
<td>Provider Customer Service Calls</td>
<td>IVR (Interactive Voice Response): 1.866.238.9650 (Mon.-Fri., 7:00a - 9:00p CST; Sat., 6:00a - 4:00p CST)</td>
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<td>Customer Service: 1.866.270.4909 (Mon.-Fri., 7:00a - 9:00p CST)</td>
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<td>Hearing Impaired: 1.888.204.3771 (Mon.-Fri., 7:00a - 9:00p CST)</td>
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<td>Beneficiary Customer Service Calls</td>
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<tr>
<td>Written Inquiries</td>
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<tr>
<td>Claim Reopenings (Adjustments)</td>
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<td>PO Box 20010, Nashville, TN 37202</td>
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<td>Fax: 1.615.782.4649</td>
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<td>Telephone requests for Reopenings: 1.866.813.7878 (8:00a - 10:30a and 12:00p – 3:30p CST)</td>
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<td>Claim Status Inquiry &amp; Beneficiary Eligibility</td>
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<td>Phone: 1.888.315.6930</td>
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<td>Overnight or Special Shipping</td>
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<td>Palmetto GBA * AG-495</td>
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<td>PO Box 100142, Columbia, SC 29202-3142</td>
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