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

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From the Medical Director

**Education Couldn’t Be Easier at CGS**

Columnist Abigail Van Buren of “Dear Abby” fame once said “True, a little learning is a dangerous thing, but it still beats total ignorance.” CGS offers more than just a little learning about Medicare and how to submit claims correctly. The best place to start the educational journey is at the CGS website: [http://www.cgsmedicare.com/jc/index.html](http://www.cgsmedicare.com/jc/index.html). On the CGS website, you’ll have access to schedules for upcoming webinars and in-person seminars conducted by our Provider Outreach and Education staff, tips for claim submission to help you get it right the first time and information about fee schedules, coverage policies and more.

Navigating the CGS website couldn’t be easier. Using the links on the left-hand side of the page, you will find the following information:

- **Claims** – Tips for how to appeal a claim decision, online claim information and beneficiary eligibility, the Comprehensive Error Rate Testing (CERT) program and more.
- **Coverage and Pricing** – This is where you find information on fee schedules, local coverage determinations and Medical Review (including “Dear Physician” letters and Documentation Checklists)
- **Education** – This link has all of the offerings from Provider Outreach and Education including webinar schedules, the Online Education Center and links to video education. Also included here is a link to CGS’ Facebook page.
- **FAQs** – Choose from a variety of topics in a Question and Answer format, drawn from inquiries at seminars, Customer Service calls and other sources.
- **Forms** – Everything forms! Included here are Reconsideration Requests forms, Advance Determination of Medicare Coverage (ADMC) requests and more.
- **News and Publications** – Click here to find out the latest Medicare news, view past editions of the DME MAC Insider and look up information in the Jurisdiction C Supplier Manual.
- **Tools and Site Map** – Need to find out why CERT denied your claim? Not sure which modifier to use? Want to calculate just how long you have left to file that Appeal? This is the link that has all that and more!
- **Customer Service** – Here’s where you’ll find information on submitting a question to Customer Service, contact CGS’ CMS Project Officer Ed Lain, and find out all of the information available on the Interactive Voice Response (IVR) system.

The website also has frequently accessed information through the quick links on the right-hand side of the page. CGS encourages suppliers, physicians and other stakeholders to check out [http://www.cgsmedicare.com/jc/index.html](http://www.cgsmedicare.com/jc/index.html) frequently to stay up-to-date on the latest Medicare news and educational information. Want the information sent directly to you? Sign up for the CGS Jurisdiction C ListServ at [http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp](http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp) or through the QuickLink on the right-hand side of the homepage.

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

Chiropractor Limitations - Coverage Reminder

DMEPOS suppliers are reminded that the Social Security Act ($1861(r)) restricts ordering by chiropractors to treatment by means of manual manipulation of the spine to correct a subluxation, provided such treatment is legal in the State where performed. Claims for any other item(s) or services prescribed by a chiropractor, including durable medical equipment, prosthetics, orthotics or supplies are denied as statutorily non-covered.

NDC for Capecitabine (Xeloda®) 500 mg. Dosage Form – European Formulation Blister Pack

The Pricing, Data Analysis, and Coding Contractor (PDAC) have the new NDC for this preparation of capecitabine included in the NDC Crosswalk posted on http://www.dmepdac.com.

NDC number 00004-1101-75 for the European version of Xeloda 500 mg. dosage form in the blister pack is effective for claims with dates of service on or after 03/29/2011 received by the DME MAC on or after 05/09/2011.


Glucose Monitor Supplies: Use of Upgrade Modifiers - Revised

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare’s coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it. For glucose monitor supplies, if the quantity of test strips and lancets that is provided exceeds the standard amount specified in the LCD and if the supplier does not have information indicating that all of the criteria for coverage of the excess quantities have been met (i.e., criteria [a]-[f] in the Glucose Monitors Local Coverage Determination), that quantity can be considered an upgrade.

General information about the use of upgrade modifiers is found in the Jurisdiction C Supplier Manual, Chapter 6. Applying this to test strips and lancets, if a supplier wants to collect from the beneficiary for the excess quantity of supplies, a properly completed ABN must be obtained. If an ABN is obtained, on one claim line the supplier bills the appropriate HCPCS code with a GA modifier and bills the units of service that describe the quantity of supplies that were provided. On the next claim line, the supplier bills the same HCPCS code with a GK modifier and bills the units of service that describe the standard quantity of supplies that are covered based on the LCD.

Note: The codes must be billed in this specific order on the claim.

In this situation, the claim line with the GA modifier will be denied as not medically necessary with a “patient responsibility” (PR) message and the claim line with the GK modifier will continue through the usual claims processing. The beneficiary liability will be the sum of (a) the difference between the submitted charge for the GA claim line and the submitted charge for the GK claim line and (b) the deductible and coinsurance that relate to the allowed charge for the GK claim line.

Note: When using the upgrade modifiers, the submitted charge for the upgrade (GA modifier line) – i.e., the quantity of supplies that were provided – may be the supplier’s “usual and customary” fee for the upgraded item.

If a supplier wants to provide the excess quantity of supplies without any additional charge to the beneficiary, then no ABN is obtained. The supplier bills the HCPCS code with a GL modifier and bills the units of service that describe the quantity of supplies that are covered based on the LCD. The quantity of supplies that is provided is not billed.

When using an upgrade modifier for excess quantities of test strips, suppliers are not required to include on the claim the brand name of the product(s) or an explanation for why it is considered an upgrade.

Codes with a GK or GL modifier will continue through the usual claims processing. For test strips and lancets, if the units of service on the GK/GL claim line are within the policy guidelines, then that claim line will not hit an edit which is focused on individual claims lines with excess units of service. If no other edits hit the claim line, payment will be made based on the units of service billed for the code with the GK or GL modifier.

Example: The physician orders testing twice per day for a non-insulin treated patient. The supplier provides 4 vials of test strips (50 in each) and 2 boxes of lancets (100 in each) as a three month supply. The supplier is unable to confirm that there is documentation in the patient’s medical record that justifies the need for twice per day testing and/or documentation (e.g., beneficiary log) that the beneficiary is testing at that frequency.

If the supplier wants to collect payment for the excess quantity of supplies from the beneficiary and obtains a properly completed ABN, the claim is billed as:

- Line 1 – A4253NUKSGA, 4 UOS, 90 day date span
- Line 2 – A4253NUKSGK, 2 UOS, 90 day date span
- Line 3 – A4259NUKSGA, 2 UOS, 90 day date span
- Line 4 – A4259NUKSGK, 1 UOS, 90 day date span

If the supplier does not want to collect payment for the excess quantity from the beneficiary, no ABN is obtained and the supplier bills:

- Line 1 – A4253NUKSGL, 2 UOS, 90 day date span
- Line 2 – A4259NUKSL, 1 UOS, 90 day date span

Shoes and Foot Inserts - Coverage Reminder

Recently questions have been asked about coverage of shoes and inserts for Medicare beneficiaries. Medicare coverage of shoes and inserts is limited by benefit categories established in the Social Security Act. The information below summarizes the key statutory and benefit requirements related to shoes and inserts.

Therapeutic Shoes and Inserts for Persons with Diabetes

Social Security Act §1861(s)(12) and 1833(c) provides for coverage of therapeutic shoes and inserts for persons with diabetes mellitus. This is a separate Medicare benefit distinct from the durable medical equipment (DME) or orthotics benefits. Under the Therapeutic Shoes benefit, beneficiaries are entitled to one (1) pair of shoes and three (3) sets of inserts each calendar year. In order to qualify for coverage under this benefit, the beneficiary must have a diagnosis of diabetes. Therapeutic shoes and inserts for beneficiaries with conditions other than diabetes mellitus are non-covered (no benefit) with the exception noted below.

Claims for therapeutic shoes and inserts for persons with diabetes utilize specific Healthcare Common Procedure Coding System (HCPCS) codes. Those codes are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A5500</td>
<td>FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF OFF-THE-SHELF DEPTH-INLAY SHOE MANUFACTURED TO ACCOMMODATE MULTI-DENSITY INSERT(S), PER SHOE</td>
</tr>
<tr>
<td>A5501</td>
<td>FOR DIABETICS ONLY, FITTING (INCLUDING FOLLOW-UP), CUSTOM PREPARATION AND SUPPLY OF SHOE MOLDED FROM CAST(S) OF PATIENT'S FOOT (CUSTOM MOLDED SHOE), PER SHOE</td>
</tr>
<tr>
<td>A5503</td>
<td>FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH ROLLER OR RIGID ROCKER BOTTOM, PER SHOE</td>
</tr>
<tr>
<td>A5504</td>
<td>FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH WEDGE(S), PER SHOE</td>
</tr>
<tr>
<td>A5505</td>
<td>FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH METATARSAL BAR, PER SHOE</td>
</tr>
<tr>
<td>A5506</td>
<td>FOR DIABETICS ONLY, MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE WITH OFF-SET HEEL(S), PER SHOE</td>
</tr>
<tr>
<td>A5507</td>
<td>FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE</td>
</tr>
<tr>
<td>A5508</td>
<td>FOR DIABETICS ONLY, DELUXE FEATURE OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE</td>
</tr>
<tr>
<td>A5510</td>
<td>FOR DIABETICS ONLY, DIRECT FORMED, COMPRESSION MOLDED TO PATIENT'S FOOT WITHOUT EXTERNAL HEAT SOURCE, MULTIPLE-DENSITY INSERT(S) PREFABRICATED, PER SHOE</td>
</tr>
<tr>
<td>A5512</td>
<td>FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT’S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHOE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHOE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH</td>
</tr>
</tbody>
</table>

As noted in the code descriptors above, these codes are used to bill claims only for beneficiaries with diabetes and who meet the qualifying coverage criteria outlined in the Social Security Act, Medicare Benefit Policy Manual (Internet-only Pub. 100-2, Chapter 15, Section 140) and the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) local coverage determination (LCD) and related policy article entitled Therapeutic Shoes for Persons with Diabetes.

Orthopedic Shoes and Modification

Orthopedic shoes are excluded from coverage by the Social Security Act, §1862(a)(8). In addition, the Act specifically excludes treatment and devices for flat feet, subluxations of the foot and routine foot care (see SSA §1862(a)(13)). The only exceptions to these benefit category provisions are:

1. Use of an orthopedic shoe(s) attached to a brace in which case coverage is governed by the brace/orthotic benefit in the Act §1861(s)(9) with additional guidance in the Medicare Benefit Policy Manual (Internet-only Pub. 100-2, Chapter 15, Section 130), the Medicare Claims Processing Manual (Internet-only Pub. 100-4, Chapter 20, various sections) and the DME MAC LCD and related policy article entitled Orthopedic Footwear.

2. For persons with diabetes only, substitution of modification(s) of custom-molded or depth shoes instead of obtaining a pair(s) of inserts in any combination. Payment for the modification(s) may not exceed the limit set for the inserts for which the individual is entitled.

In other words, orthopedic shoes, inserts and modifications billed using the HCPCS codes below may only be billed when attached to a brace, in which case the shoes, inserts and/or modifications must be billed by the supplier billing the brace or as a substitute for inserts in beneficiaries entitled to therapeutic shoes and inserts by virtue of a diabetes diagnosis.

The HCPCS codes billed for orthopedic shoes, inserts and modifications as described above are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A5513</td>
<td>FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT'S FOOT, TOTAL CONTACT WITH PATIENT'S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER, INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH</td>
</tr>
<tr>
<td>A9283</td>
<td>FOOT PRESSURE OFF LOADING/SUPPORTIVE DEVICE, ANY TYPE, EACH</td>
</tr>
<tr>
<td>L3000</td>
<td>FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, ‘UCB’ TYPE, BERKELEY SHELL, EACH</td>
</tr>
<tr>
<td>L3001</td>
<td>FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SPENC, EACH</td>
</tr>
<tr>
<td>L3002</td>
<td>FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, PLASTAZOTE OR EQUAL, EACH</td>
</tr>
<tr>
<td>L3003</td>
<td>FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, SILICONE GEL, EACH</td>
</tr>
<tr>
<td>L3010</td>
<td>FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL ARCH SUPPORT, EACH</td>
</tr>
<tr>
<td>L3020</td>
<td>FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, LONGITUDINAL/ METATARSAL SUPPORT, EACH</td>
</tr>
<tr>
<td>L3030</td>
<td>FOOT, INSERT, REMOVABLE, FORMED TO PATIENT FOOT, EACH</td>
</tr>
<tr>
<td>Item Code</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>L3031</td>
<td>FOOT, INSERT/PLATE, REMOVABLE, ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPPREG COMPOSITE, EACH</td>
</tr>
<tr>
<td>L3040</td>
<td>FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL, EACH</td>
</tr>
<tr>
<td>L3050</td>
<td>FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, METATARSAL, EACH</td>
</tr>
<tr>
<td>L3060</td>
<td>FOOT, ARCH SUPPORT, REMOVABLE, PREMOLDED, LONGITUDINAL/METATARSAL, EACH</td>
</tr>
<tr>
<td>L3070</td>
<td>FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL, EACH</td>
</tr>
<tr>
<td>L3080</td>
<td>FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, METATARSAL, EACH</td>
</tr>
<tr>
<td>L3090</td>
<td>FOOT, ARCH SUPPORT, NON-REMOVABLE ATTACHED TO SHOE, LONGITUDINAL/METATARSAL, EACH</td>
</tr>
<tr>
<td>L3100</td>
<td>HALLUS-VALGUS NIGHT DYNAMIC SPLINT</td>
</tr>
<tr>
<td>L3140</td>
<td>FOOT, ABDUCTION ROTATION BAR, INCLUDING SHOES</td>
</tr>
<tr>
<td>L3150</td>
<td>FOOT, ABDUCTION ROTATION BAR, WITHOUT SHOES</td>
</tr>
<tr>
<td>L3160</td>
<td>FOOT, ADJUSTABLE SHOE-STYLED POSITIONING DEVICE</td>
</tr>
<tr>
<td>L3170</td>
<td>FOOT, PLASTIC, SILICONE OR EQUAL, HEEL STABILIZER, EACH</td>
</tr>
<tr>
<td>L3201</td>
<td>ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, INFANT</td>
</tr>
<tr>
<td>L3202</td>
<td>ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, CHILD</td>
</tr>
<tr>
<td>L3203</td>
<td>ORTHOPEDIC SHOE, OXFORD WITH SUPINATOR OR PRONATOR, JUNIOR</td>
</tr>
<tr>
<td>L3204</td>
<td>ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, INFANT</td>
</tr>
<tr>
<td>L3206</td>
<td>ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, CHILD</td>
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<tr>
<td>L3207</td>
<td>ORTHOPEDIC SHOE, HIGHTOP WITH SUPINATOR OR PRONATOR, JUNIOR</td>
</tr>
<tr>
<td>L3208</td>
<td>SURGICAL BOOT, EACH, INFANT</td>
</tr>
<tr>
<td>L3209</td>
<td>SURGICAL BOOT, EACH, CHILD</td>
</tr>
<tr>
<td>L3211</td>
<td>SURGICAL BOOT, EACH, JUNIOR</td>
</tr>
<tr>
<td>L3212</td>
<td>BENESCH BOOT, PAIR, INFANT</td>
</tr>
<tr>
<td>L3213</td>
<td>BENESCH BOOT, PAIR, CHILD</td>
</tr>
<tr>
<td>L3214</td>
<td>BENESCH BOOT, PAIR, JUNIOR</td>
</tr>
<tr>
<td>L3215</td>
<td>ORTHOPEDIC FOOTWEAR, LADIES SHOE, OXFORD, EACH</td>
</tr>
<tr>
<td>L3216</td>
<td>ORTHOPEDIC FOOTWEAR, LADIES SHOE, DEPTH INLAY, EACH</td>
</tr>
<tr>
<td>L3217</td>
<td>ORTHOPEDIC FOOTWEAR, LADIES SHOE, HIGHTOP, DEPTH INLAY, EACH</td>
</tr>
<tr>
<td>L3219</td>
<td>ORTHOPEDIC FOOTWEAR, MENS SHOE, OXFORD, EACH</td>
</tr>
<tr>
<td>L3221</td>
<td>ORTHOPEDIC FOOTWEAR, MENS SHOE, DEPTH INLAY, EACH</td>
</tr>
<tr>
<td>L3222</td>
<td>ORTHOPEDIC FOOTWEAR, MENS SHOE, HIGHTOP, DEPTH INLAY, EACH</td>
</tr>
<tr>
<td>L3224</td>
<td>ORTHOPEDIC FOOTWEAR, WOMAN’S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOSIS)</td>
</tr>
<tr>
<td>L3225</td>
<td>ORTHOPEDIC FOOTWEAR, MAN’S SHOE, OXFORD, USED AS AN INTEGRAL PART OF A BRACE (ORTHOSIS)</td>
</tr>
<tr>
<td>L3230</td>
<td>ORTHOPEDIC FOOTWEAR, CUSTOM SHOE, DEPTH INLAY, EACH</td>
</tr>
<tr>
<td>L3250</td>
<td>ORTHOPEDIC FOOTWEAR, CUSTOM MOLDED SHOE, REMOVABLE INNER MOLD, PROSTHETIC SHOE, EACH</td>
</tr>
<tr>
<td>L3251</td>
<td>FOOT, SHOE MOLDED TO PATIENT MODEL, SILICONE SHOE, EACH</td>
</tr>
<tr>
<td>L3252</td>
<td>FOOT, SHOE MOLDED TO PATIENT MODEL, PLASTAZOTE (OR SIMILAR), CUSTOM FABRICATED, EACH</td>
</tr>
<tr>
<td>L3253</td>
<td>FOOT, MOLDED SHOE PLASTAZOTE (OR SIMILAR) CUSTOM FITTED, EACH</td>
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<td>L3254</td>
<td>NON-STANDARD SIZE OR WIDTH</td>
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<td>L3255</td>
<td>NON-STANDARD SIZE OR LENGTH</td>
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<td>L3257</td>
<td>ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE FOR SPLIT SIZE</td>
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<td>L3260</td>
<td>SURGICAL BOOT/SHOE, EACH</td>
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<tr>
<td>L3265</td>
<td>PLASTAZOTE SANDAL, EACH</td>
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<tr>
<td>L3300</td>
<td>LIFT, ELEVATION, HEEL, TAPERED TO METATARSALS, PER INCH</td>
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<td>LIFT, ELEVATION, HEEL AND SOLE, NEOPRENE, PER INCH</td>
</tr>
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<td>LIFT, ELEVATION, HEEL AND SOLE, CORK, PER INCH</td>
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<td>L3330</td>
<td>LIFT, ELEVATION, METAL EXTENSION (SKATE)</td>
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<td>LIFT, ELEVATION, INSIDE SHOE, TAPERED, UP TO ONE-HALF INCH</td>
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<td>L3334</td>
<td>LIFT, ELEVATION, HEEL, PER INCH</td>
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<tr>
<td>L3350</td>
<td>HEEL WEDGE</td>
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<tr>
<td>L3360</td>
<td>SOLE WEDGE, OUTSIDE SOLE</td>
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<td>L3370</td>
<td>SOLE WEDGE, BETWEEN SOLE</td>
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<td>L3380</td>
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<td>L3390</td>
<td>OUTFLARE WEDGE</td>
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<td>L3400</td>
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<td>METATARSAL BAR WEDGE, BETWEEN SOLE</td>
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<td>FULL SOLE AND HEEL WEDGE, BETWEEN SOLE</td>
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<td>L3430</td>
<td>HEEL, COUNTER, PLASTIC REINFORCED</td>
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<td>L3440</td>
<td>HEEL, COUNTER, LEATHER REINFORCED</td>
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<tr>
<td>L3450</td>
<td>HEEL, SACH CUSHION TYPE</td>
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<tr>
<td>L3455</td>
<td>HEEL, NEW LEATHER, STANDARD</td>
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<td>L3460</td>
<td>HEEL, NEW RUBBER, STANDARD</td>
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<td>L3465</td>
<td>HEEL, THOMAS WITH WEDGE</td>
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<td>HEEL, THOMAS EXTENDED TO BALL</td>
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<tr>
<td>L3480</td>
<td>HEEL, PAD AND DEPRESSION FOR SPUR</td>
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<td>L3485</td>
<td>HEEL, PAD, REMOVABLE FOR SPUR</td>
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<td>L3500</td>
<td>ORTHOPEDIC SHOE ADDITION, INSOLE, LEATHER</td>
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<td>ORTHOPEDIC SHOE ADDITION, INSOLE, RUBBER</td>
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<td>ORTHOPEDIC SHOE ADDITION, INSOLE, FELT COVERED WITH LEATHER</td>
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<td>ORTHOPEDIC SHOE ADDITION, SOLE, HALF</td>
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<td>ORTHOPEDIC SHOE ADDITION, SOLE, FULL</td>
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<td>ORTHOPEDIC SHOE ADDITION, TOE TAP, HORSESHOE</td>
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<td>L3570</td>
<td>ORTHOPEDIC SHOE ADDITION, SPECIAL EXTENSION TO INSTEP (LEATHER WITH EYELETS)</td>
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<td>L3580</td>
<td>ORTHOPEDIC SHOE ADDITION, CONVERT INSTEP TO VELCRO CLOSURE</td>
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<td>L3590</td>
<td>ORTHOPEDIC SHOE ADDITION, CONVERT FIRM SHOE COUNTER TO SOFT COUNTER</td>
</tr>
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<td>L3595</td>
<td>ORTHOPEDIC SHOE ADDITION, MARCH BAR</td>
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<tr>
<td>L3600</td>
<td>TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE, EXISTING</td>
</tr>
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<td>L3610</td>
<td>TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, CALIPER PLATE, NEW</td>
</tr>
<tr>
<td>L3620</td>
<td>TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, SOLID STIRRUP, EXISTING</td>
</tr>
<tr>
<td>L3630</td>
<td>TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, SOLID STIRRUP, NEW</td>
</tr>
<tr>
<td>L3640</td>
<td>TRANSFER OF AN ORTHOSIS FROM ONE SHOE TO ANOTHER, DENNIS BROWNE SPLINT (RIVETON), BOTH SHOES</td>
</tr>
<tr>
<td>L3649</td>
<td>ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED</td>
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This article is a summary of selected coverage, coding and documentation requirements for shoes, inserts and...
Orthopedic Shoes: HCPCS Code L3000 - Billing Reminder

Recently inquiries have been received regarding the proper use and billing for Healthcare Common Procedure Coding System (HCPCS) code L3000. This code describes a shoe insert billed when provided with an orthopedic shoe attached to a brace.

L3000 FOOT, INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, ‘UCB’ TYPE, BERKELEY SHELL, EACH

Suppliers and providers are reminded that orthopedic shoes are excluded from coverage by the Social Security Act, §1862(a)(8) except in very limited circumstances, described below. In addition, the Act specifically excludes treatment and devices for flat feet, subluxations of the foot and routine foot care (see SSA §1862(a)(13)). The only exceptions to these benefit category provisions are:

1. Use of an orthopedic shoe(s) attached to a brace in which case coverage is governed by the brace/orthotic benefit in the Act §1861(s)(9) with additional guidance in the Medicare Benefit Policy Manual (Internet-only Pub. 100-2, Chapter 15, Section 130), the Medicare Claims Processing Manual (Internet-only Pub. 100-4, Chapter 20, various sections) and the DME MAC LCD and related policy article entitled Orthopedic Footwear.

2. For persons with diabetes only, substitution of modification(s) of custom-molded or depth shoes instead of obtaining a pair(s) of inserts in any combination. Payment for the modification(s) may not exceed the limit set for the inserts for which the individual is entitled.

In other words, orthopedic shoes, inserts and modifications may only be billed when attached to a brace, in which case the shoes, inserts and/or modifications must be billed by the supplier billing the brace or as a substitute for inserts in beneficiaries entitled to therapeutic shoes and inserts by virtue of a diabetes diagnosis.

For additional information on the proper coding, coverage and documentation requirements for orthopedic shoes, inserts and modifications refer to the DME MAC local coverage determination and related policy article Orthopedic Shoes at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.


Effective for items provided on or after January 1, 2011, standard power wheelchairs (K0813 - K0831, K0898) must be furnished on a monthly rental basis like other capped rental durable medical equipment (DME). The following are questions and answers from suppliers regarding application of the Power Mobility Devices medical policy and CMS payment policy rules to rented power wheelchairs.

Short-Term Use

1. When standard power wheelchairs (PWCs) are provided on a rental basis, can they be covered for short-term indications?

   Response: No. The change in the payment policy status for power wheelchair does not change the policy statement that PWCs are not covered for patients with short term, reversible conditions.

2. A short-term rental would occur if the beneficiary were to pass away in the second month of the rental period. Will a short duration in billing signal that a short-term rental has occurred and flag the claim for review?

   Response: If all the criteria are met for coverage of a PWC and the initial rental months are paid but the beneficiary dies within the first 3 months or the patient goes into a nursing home on a permanent basis during the first 3 months, that does not affect coverage of those initially paid rental months.

Change of Residence

3. Is it advisable for the supplier to document in their records that they have contacted the beneficiary and confirmed that the beneficiary is able to use the PWC they are renting in their new residence?

   Response: There is no requirement for a supplier to reassess the home in the event that a beneficiary changes residence.

4. If the new residence will not accommodate the PWC the beneficiary is currently renting and a different base (same HCPCS code) is required will the supplier need to obtain a new detailed product description for the item that can be used in the home?

   Response: Medicare would not start a new-capped rental period in this situation. If the supplier elects to provide a different wheelchair base (different HCPCS code), a new signed and dated detailed product description is needed but a new face-to-face examination or 7-element order is not needed.

5. If a patient with a PWC moves and their new home will no longer accommodate the PWC that they have, will Medicare pay for a new PWC?

   Response: No. Medicare covers a replacement only if an item is lost, stolen, irreparably damaged, or reaches the 5 year reasonable useful lifetime. Medicare covers a different item only if there is a change in the beneficiary’s medical condition.
Break in Service

6. A PWC is being rented and the beneficiary goes into a hospital and nursing home for an extended stay. The supplier elects to pick up the wheelchair. When the beneficiary is ready to go back home, would there be a problem with providing a different model wheelchair within the same HCPCS code?

Response: If the supplier chooses to deliver a different model of PWC within the same code, a new detailed product description must be obtained. A new face-to-face (FTF) examination or 7-element order is not needed.

7. If a patient who is renting a PWC goes into a hospital/nursing home for an extended time and the supplier picks up the wheelchair and the beneficiary is discharged to home, would a new capped rental period start and what documentation would be required?

Response: Existing capped rental rules for beginning a new rental period apply to power wheelchairs. That policy states that a new capped-rental period will begin only if there has been a break in medical necessity of at least 60 days plus the days remaining in the last paid rental month. In the situation that is described, “medical necessity” would continue while the patient was in a facility. If the patient is receiving the same type of PWC (same code) on discharge that they previously had, then the rental period resumes where it left off and no additional documentation is needed (other than a new detailed product description if the make/model of the wheelchair has changed). If the patient needs a different type of PWC on discharge because of a change in their medical condition, all the requirements for a new PWC must be met (i.e., FTF exam, 7-element order, etc.).

8. If the beneficiary is renting a PWC coded K0823 prior to entering the hospital, would a new rental episode begin if, while in the hospital, they develop a Stage II decubitus ulcer over the sacrum and upon discharge require a PWC coded K0822 and a skin protection cushion, E2603?

Response: Yes. However, following standard rules, since it is a different item, there would have to be a new face-to-face examination (which documents the medical necessity for the new item), 7-element order, detailed product description, home assessment, etc.

Repair/Replacement

9. If, during a capped rental period, a PWC is lost, stolen, or irreparably damaged and a new PWC is provided, does a new CR period start?

Response: Yes. Replacement of power wheelchairs will follow the same rules as any other rented DME item.

10. Medicare provides for the replacement of lost, stolen, or irreparably damaged items but we are concerned as to how this fits with Supplier Standard # (14), which states: “Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced.” Can you please clarify, as this is a significant concern for providers and beneficiaries?

Response: The Supplier Standards address situations related to non-function or damage of an item that can be repaired or to replacement of an item due to wear and tear. Lost, stolen, or irreparably damaged items are a different category.

The Medicare Benefit Policy Manual, Chapter 15, Section 110.2(A) states:

Since renters of equipment recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for repair of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental and inexpensive or routinely purchased payment categories which are being rented.

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment.

This means that replacement due to wear and tear is possible only after the 5-year reasonable useful lifetime.

The Medicare Benefit Policy Manual, Chapter 15, Section 110.2(C) defines payment policy for items that are lost or that have been irreparably damaged by an acute incident:

Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood).

11. Is there any situation in which a supplier can be paid for repair to a PWC during a capped period - e.g., if the supplier has information to indicate that the repair is required due to “malicious damage” or “culpable neglect” by the beneficiary?

Response: There can be no payment for the repair of rented items under any circumstances. Reimbursement for repairs is included in the rental payments.

If the supplier believes that a wheelchair repair is required because of malicious damage or culpable neglect by the beneficiary, the supplier can present the information to the DME MAC for investigation. If the DME MAC, in consultation with the CMS, agrees that the beneficiary is responsible for the damage, the supplier can charge the beneficiary.

12. How does a supplier alert the DME MAC that they believe the PWC requires a repair secondary to malicious damage or culpable neglect?

Response: The supplier can contact the provider customer service department. That staff will forward the information to the appropriate DME MAC staff.
Who is responsible for determining when a beneficiary is responsible for the damage and how will this be communicated?

**Response:** As discussed in a previous question, the DME MAC will consult with CMS to make that determination. Since these are very rare situations, there is no established procedure. They will be handled on an individual basis.

Unique to power wheelchairs is the fact that beneficiaries often use the products outside the home as well as inside. This is generally not done with other capped rental items (e.g., hospital beds never leave the home). If a PWC is damaged outside the home, since that is not an approved use per Medicare, will the supplier be expected to repair the chair “at no charge” during the rental period?

**Response:** Yes, the supplier is responsible for the repair. Statutory coverage of DME requires that it be needed for use inside the home. However, if that requirement is met, the item may be used outside the home. Portable oxygen, nebulizers, walkers, canes, crutches, POVs, manual and power wheelchairs are among the many items, both rental and purchase, that are routinely used outside of the home setting. During the rental period, the supplier is expected to repair an item if the repair was related to damage that occurred either inside or outside the home. For purchased and rental items where the title has transferred, repairs are covered under the general repair rules.

How would a supplier prove the damage occurred outside the home (unless it is obvious, like sand/mud/water in the motor)?

**Response:** Use of a DME item outside of the home is not deemed evidence of deliberate malicious damage or culpable neglect.

If the beneficiary has a power chair under rental and the power chair has a service/repair issue, is it permissible to provide the beneficiary with a loaner manual wheelchair while the power wheelchair is being repaired or is the supplier required to replace the power wheelchair?

**Response:** The supplier is required to provide a loaner item that meets the beneficiary’s medical need.

While their rental power wheelchair is being repaired, does monthly billing for the power wheelchair continue?

**Response:** Yes, monthly billing for the power wheelchair would continue. There should be no separate billing and/or payment for the loaner wheelchair during the 13 month capped rental period.

If a replacement power wheelchair of the same HCPCS code is provided, but it is a different manufacturer, make or model than the power wheelchair listed on the detailed product description (DPD) is a new DPD required for billing the months following the replacement?

**Response:** Replacement of a PMD at the end of the 5 yr. useful lifetime requires a complete reassessment following the same rules as if a new initial PMD was being provided.

How will the “look back” period affect the review of PWCs?

**Response:** There is a general policy that coverage of items that are provided on an ongoing basis, including rented DME, is dependent on there being continued need for the item and continued use by the beneficiary. CMS and the DME MACs have not published any information regarding the look back period.

Will elevating leg rests (already a mandatory capped rental item) be paid at 15% in months 1-3 and 6% in months 4-13 or will they remain at a payment rate of 10% in months 1-3 and 7.5% in months 4-13?

**Response:** Payment policy for accessories is not changing.

If payment for separately billable items at initial issue will be at the front loaded rate how will these items be distinguished as receiving a different payment methodology from the same items (other than batteries) on a MWC?

**Response:** Payment policy for accessories is not changing.

Will a “patient requested upgrade” from a Group 2 power wheelchair (K0822 – K0831) to a Group 3 power wheelchair base (K0848 – K0855) retain the option to purchase the chair in the first month?

**Response:** No, the application of upgrade provisions does not change the payment rules for any item.

Do PMD documentation requirements differ in any way since the elimination of the first month purchase option for beneficiaries living in a zip-coded area outside of a competitive bid area (CBA)?

**Response:** The documentation requirements do not differ based upon whether the Power Mobility Device is paid as a rental in a non-CBA or as a purchase in a CBA.

Must supplier records document ongoing use of the power mobility device by the beneficiary during the 13-month rental or is a physician order indicating Lifetime Use sufficient?

**Response:** For power mobility devices that are provided under the rent to purchase guidelines over 13 months, it is expected that the supplier records will substantiate the beneficiary’s ongoing use of the PMD for the period for which claims are submitted.

Is there a requirement mandating that contact with the beneficiary must be made at certain intervals to determine if a PMD meets the ongoing use requirement?
Response: If a beneficiary discontinues use of a rental DME item, the supplier may not continue to bill Medicare for that item. Although Medicare does not have specific guidelines on how a supplier should monitor and document use, each claim submitted may be subject to review. Supplier records must clearly demonstrate ongoing monitoring and use of the rental item by the beneficiary if audited.

27. If a physician’s order documents lifetime medical necessity for a PMD, must the physician’s medical record indicate that the patient has been seen during the 13-month period and document that ongoing medical necessity is met?

Response: The PMD policy does not mandate that the treating physician must formally monitor and/or recertify these devices on a scheduled basis. However, each claim may be subject to review to determine whether payment continues to be justified. Thus, some evidence must be present in the medical record demonstrating that the initial qualifying medical condition(s) continues to be present and that the need for the item continues. This may be noted intermittently throughout the course of the rental cycle.

Drugs Used With External Infusion Pumps – Coverage and Billing Reminders

Coverage of drugs used with external infusion pumps may have differing denials. It is important for suppliers of these drugs to understand the issues related to coverage and denials. Understanding coverage necessarily starts with a discussion of benefit category. Fee-for-Service Medicare is a defined benefit program. Without a statutorily defined benefit, there can be no reimbursement from Medicare. External infusion pumps are covered under the DME benefit, however, there is no separate, specific benefit established for the payment of drugs used in external infusion pumps. Drugs used in conjunction with a covered pump are considered a supply item for the pump and are eligible for reimbursement only on that basis. This means that all infusion drug claims not associated with an external infusion pump will receive a statutorily non-covered denial.

Coverage must also take into consideration the applicable reasonable and necessary (R&N) criteria (also known as medical necessity criteria). National and Local Coverage Determinations (NCD and LCD) contain the R&N rules that are applicable to pumps and infusion drugs. For external infusion pumps, the LCD lists the only covered drugs. For many of the drugs, additional specific R&N criteria also apply. Reimbursement for the pump and drug is possible only when a listed drug is provided to a beneficiary meeting all the criteria specified in the LCD. Failure to meet these criteria results in a not reasonable and necessary denial.

Four possible scenarios can result when billing the DME MAC for drugs used with an external infusion pump:

1. Billing for an infusion drug alone (no pump being used).
   There is no statutory infusion drug benefit to allow coverage. All infusion drugs and any associated supplies will be denied as statutorily non-covered.

2. Billing for a pump with an infusion drug not listed in the LCD. The pump is eligible for coverage under the DME benefit, but because the drug is not listed in the LCD, all items (the pump, drug, and any associated supplies) will be denied as not reasonable and necessary.

3. Billing for a pump with a drug listed in the LCD but the R&N criteria for the drug are not met. The pump, drug, and any associated supplies will be denied as not reasonable and necessary.

4. Billing for a pump with a drug listed in the LCD where the R&N criteria for the drug are met. The pump, drug and any associated supplies are payable if other conditions of coverage are met.

Billing Instructions – ABNs and Modifiers

When the beneficiary does not meet the R&N criteria in an LCD, if the supplier elects to hold the beneficiary financially liable, suppliers may execute an Advance Beneficiary Notice of Non-coverage (ABN) for all items addressed by the policy. Refer to the Supplier Manual for additional information on the use of ABNs.

There are several modifiers associated with the billing of external infusion pumps, infusion drugs, and associated supplies. Each modifier has specific associated usage criteria that are discussed in the Documentation Requirements section of the LCD. Incorrect or inappropriate application of modifiers can result in claim denials or improper assignment of liability. For items addressed by the External Infusion Pump LCD, the modifiers are:

- **EY** – No physician or other licensed health care provider order for this item or service. Use this modifier when the supplier does not have a compliant detailed written order. Use of an EY modifier in this LCD results in an R&N denial.

- **GA** – Waiver of liability statement issued as required by payer policy, individual case. Use this modifier when the R&N criteria in the LCD are not met, i.e. scenarios 2 & 3 above, and the supplier elected to obtain an ABN. Use of a GA modifier results in an R&N denial with beneficiary liability.

- **GY** – Item or service statutorily excluded or does not meet the definition of any Medicare benefit. Use this modifier for items that fall into scenario 1 above. There items receive a statutory denial with beneficiary liability. An ABN is not required in order to hold the beneficiary financially liable; however, it may be used as a voluntary notice.

- **GZ** – Item or service expected to be denied as not reasonable and necessary. Use this modifier when the R&N criteria in the LCD are not met, i.e. scenarios 2 & 3 above, and the supplier elected not to obtain an ABN. Use of a GZ modifier results in an R&N denial with supplier liability.

- **KX** – Requirements specified in the medical policy have been met. In this LCD, this modifier is used only with external insulin pumps and supplies. Use this modifier when the R&N criteria in the LCD are met, i.e. scenario 4 above. Use of the KX modifier results in payment for the items addressed in this LCD.

- **JB** - Administered Subcutaneously. In this LCD, this modifier is used with immune globulins used for the treatment of primary immune deficiency administered with an external
pump (E0779) via the subcutaneous route. Immune globulins not administered subcutaneously must meet the criteria in the Intravenous Immune Globulin LCD.

**Vancomycin**

Vancomycin does not require the use of a covered external infusion pump for administration. As discussed above, the type of denial associated with claims for vancomycin depends on whether or not an external infusion pump is billed with the drug. Scenarios 1 and 2 above apply to vancomycin:

- If vancomycin is billed without a covered pump, a statutorily non-covered denial will be applied as described in scenario 1. A GY modifier is used.
- If vancomycin is billed with a covered pump, the pump, all associated supplies, and the vancomycin will be denied as not R&N as described by scenario 2. The GA or GZ modifier is used depending upon whether an ABN is executed. Use of the GY modifier is incorrect.

**Supplies Used With Functional Electrical Stimulators (FES) – E0770**

Electrodes used with a covered E0770 (FUNCTIONAL ELECTRICAL STIMULATOR, TRANSCUTANEOUS STIMULATION OF NERVE AND/OR MUSCLE GROUPS, ANY TYPE, COMPLETE SYSTEM, NOT OTHERWISE SPECIFIED) are eligible for reimbursement as long as the E0770 device meets the coverage criteria outlined in the CMS National Coverage Determination and are used by the patient. Functional electrical stimulators are a type of neuromuscular stimulator (NMES), therefore supply codes used with NMES devices are to be used with FES devices. Electrodes are billed with code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4595</td>
<td>ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)</td>
</tr>
</tbody>
</table>

A4595 is an allowance for all necessary supplies used during the month regardless of the number of lead/electrode changes made. All necessary supplies such as electrodes, coupling gel, adhesive, adhesive remover, etc. are considered as included in the monthly allowance. If two FES leads/electrodes are required then a maximum of one unit of Code A4595 would be allowed per month; if four FES leads/electrodes are necessary, a maximum of two units per month would be allowed.

There is no separate payment for supplies provided with an initial claim. Initial provision of an E0770 includes all necessary supplies. Separate billing of supplies with the initial claim is considered unbundling.

For additional information about the coverage of FES and supplies, refer to CMS IOM Pub. 100-03, **National Coverage Determination (NCD) Manual**, section 160.12.

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### Billing for Supplies Prior to Delivery of the Base Item – Billing Reminder

Supplies are a loosely defined category of items that are used with base items of DME. They are either consumed (used up) or require frequent replacement. Many DME items require supplies to be used in conjunction for the base item to be functional. Some examples (not all-inclusive) are strips and lancets used with home glucose monitors or the drugs used with infusion pumps and nebulezers.

Payment for supplies is contingent upon the coverage of the base DME item. If the DME item is covered (meets all applicable payment requirements) then supplies used with that item are also covered. Supplies sometimes have specific coverage criteria that must be met in addition to the base item before payment can be made.

No payment may be made for supplies that are billed with dates of service (DOS) prior to the initial DOS of the base item associated with the supplies. Supplies billed with a DOS before the initial DOS of the base item will be denied as statutorily non-covered (no benefit). Suppliers are encouraged to ensure that the base item is delivered on or before the delivery date of any supplies in order to avoid unnecessary denials. Sometimes multiple suppliers may be involved as in the case of nebulezers and associated drugs. This may require close coordination between all parties to avoid needless denials.

For appeals, suppliers are reminded that it is necessary to provide information from the medical record demonstrating that the coverage criteria for all items were met and that the base item was ordered, along with any supplies, prior to the DOS of the denied supplies.

Refer to the applicable LCD and Policy Article and Supplier Manual for additional information.

### Items Provided on a Recurring Basis and Request for Refill Requirements

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

#### Requirements

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

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

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

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

**Documentation Requirements**

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

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

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

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

- Beneficiary’s name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Quantity of each item that the beneficiary still has remaining

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

**Billing Frequencies**

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

For all other refills that are provided on a recurring basis, including but not limited to DME accessories or supplies, nebulizer drugs, urological and ostomy supplies, suppliers may dispense no more than a three-month supply at any one time.

**Miscellaneous**

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

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

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


For additional information, refer to CMS’ Program Integrity Manual, Internet-Only Manual, and CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6, the applicable Local Coverage Determination and the Supplier Manual.
RE: Medicare Record Authentication – Tips for Physicians

Dear Physicians:

Medicare requires that healthcare providers ordering or documenting the medical necessity for items or services received by Medicare beneficiaries must be identifiable. The Comprehensive Error Rate Testing (CERT) contractor notes that the majority of CERT errors are related to inability to identify the author of a medical record. Medical record authorship is generally accomplished through a handwritten or electronic signature (signature stamps are not acceptable); however, when the author of a record is unclear, document(s) must be authenticated. Signature logs or attestation statements are two acceptable methods to authenticate a record (excluding orders and Certificates of Medical Necessity (CMNs)).

Signature Logs

Medicare contractors recommend that physicians consider preparing a single-page signature log or “key” to include when responding to requests for documentation. A signed and dated signature log identifies the author(s) associated with initials or “illegible” signatures within a set of medical records. When a physician's office receives a request for copies of a beneficiary's medical record, the signature log may then be included and returned to the requestor. This will help prevent follow-up contacts from suppliers and auditing entities for signature verification.

Attestation Statements

In some cases, a medical record or entry omits a legible identifier requiring the author to attest to the authenticity of the record. To be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Should a provider choose to submit an attestation statement, they may choose to use the following statement:

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

While this sample statement is an acceptable format, CMS is neither requiring nor instructing providers to use a certain form or format. The above format has not been approved by the Office of Management and Budget (OMB) and therefore it is not mandatory. Note that attestation statements are not valid for orders or CMNs where the author’s signature or initials are not authenticated. An overview of the key points of CMS’ signature requirements, including signature logs and attestation statements, can also be found in MLN Matters article MM6698 (http://www.cms.gov/MLNMattersArticles/downloads/MM6698.pdf).
Electronic Signatures

Although CMS has not published formal regulations regarding electronic signatures, Medicare contractors recommend that an electronic signature be accompanied by a statement indicating that the signature was applied electronically. Some examples of electronic signature notations include (not all-inclusive):

- Electronically signed by
- Authenticated by
- Approved by
- Completed by
- Finalized by
- Signed by
- Validated by
- Sealed by

Notations such as those listed above indicate to the reviewer that the author’s name, typically applied in typed format, was electronically signed.

Sincerely,

Paul J. Hughes, MD               Robert D. Hoover, Jr., MD, MPH, FACP
Medical Director, DME MAC Jurisdiction A    Medical Director, DME MAC Jurisdiction C
Stacey V. Brennan, MD, FAAFP          Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC Jurisdiction B    Medical Director, DME MAC Jurisdiction D

Gammagard Liquid® (J1569) Added as Covered Subcutaneous Immune Globulin

Gammagard Liquid® (J1569) is added to the External Infusion Pump LCD as covered subcutaneous immune globulin effective for dates of service on or after July 22, 2011.

The existing HCPCS code for Gammagard Liquid® must be used:

| J1569 | INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), INTRAVENOUS, NONLYOPHILIZED, (E.G. LIQUID), 500 MG |

For J1569 and associated infusion pump (E0779) claims where the route of administration is subcutaneous, a JB modifier must be added to each HCPCS code. For other methods of administration, no modifier should be added.

One (1) unit of service (UOS) is 500mg. Gammagard liquid is distributed in multiple package sizes from one (1)-gram (1000mg) to thirty (30)-grams (30,000mg). Suppliers must choose the package size that is appropriate for the dosage being administered to minimize waste.

**For example:** 1500mg is prescribed (3 UOS). Gammagard liquid is available in 1-gram (2UOS) and 2.5-gram (5 UOS) sizes. Two 1-gram vials (4 UOS) must be used rather than one 2.5-gram vial (5 UOS).

Excess wastage due to non-optimal vial sizes will be denied as not reasonable and necessary.

**As a reminder, below are the coverage criteria from the External Infusion Pump LCD:** “Subcutaneous immune globulin (J1559, J1561, J1562) is covered only if criteria 1 and 2 are met:

1. The subcutaneous immune globulin preparation is a pooled plasma derivative which is approved for the treatment of primary immune deficiency disease; and
2. The patient has a diagnosis of primary immune deficiency disease (ICD-9 codes 279.04, 279.05, 279.06, 279.12, 279.2).

Coverage of subcutaneous immune globulin applies only to those products that are specifically labeled as subcutaneous administration products. Intravenous immune globulin products are not covered under this LCD.

Only an E0779 infusion pump is covered for the administration of subcutaneous immune globulin. If a different pump is used, it will be denied as not reasonable and necessary.”

Gammagard Liquid will be added in a future revision of the LCD.

Refer to the LCD, Policy Article and Supplier manual for additional information.
Documentation of Artificial Limbs
August 2011

Dear Physician,

The Durable Medical Equipment Medical Administrative Contractors (DME MAC) have jurisdiction for processing claims from prosthetists for artificial limbs. In the event of an audit, the Medicare contractor may request medical records to demonstrate that the prosthetic arm or leg was reasonable and necessary. Since the prosthetist is a supplier, the prosthetist’s records must be corroborated by the information in your patient’s medical record. It is the treating physician’s records, not the prosthetist’s, which are used to justify payment.

The patient’s functional capabilities are crucial to establishing the medical necessity for a prosthetic device. Many prosthetic components are restricted to specific functional levels; therefore, it is critical that physicians thoroughly document the functional capabilities of their patients, both before and after amputation. Clinical assessments of a patient’s rehabilitation potential must be based on the following classification levels:

- **Level 0:** Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
- **Level 1:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
- **Level 2:** Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
- **Level 3:** Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
- **Level 4:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

The records must document the patient’s current functional capabilities and his/her expected functional potential, including an explanation for the difference. Note that it is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

The physician’s assessment of a patient’s physical and cognitive capabilities typically includes:

- History of the present condition(s) and past medical history that is relevant to functional deficits
- Symptoms limiting ambulation or dexterity
- Diagnoses causing these symptoms
- Other co-morbidities relating to ambulatory problems or impacting the use of a new prosthesis
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used (either in addition to the prosthesis or prior to amputation)
- Description of activities of daily living and how impacted by deficit(s)
Physical examination that is relevant to functional deficits
- Weight and height, including any recent weight loss/gain
- Cardiopulmonary examination
- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

The assessment points above are not all-inclusive and physicians should tailor their history and examination to the individual patient’s condition, clearly describing the pre and post-amputation capabilities of the patient. 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 or upper extremity difficulties or impact on the patient’s functional ability.

Note that when physicians are unable to provide the requested documentation to the supplier, the suppliers receive denials for the items billed which could result in your patient being financially responsible for all or part of the charges for the items/service received. If a supplier contacts your office to request additional clinical documentation, please partner with the supplier to establish what clinical records are needed to support that the service/item you ordered is medically necessary.

Section 1842(p)(4) of the Social Security Act mandates that:

[i]n case of an item or service . . . ordered by a physician or a practitioner . . . but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Providing medical records to the supplier is not a violation of the HIPAA Privacy Rule. Thank you for your cooperation in future documentation requests.

Sincerely,

Paul J. Hughes, MD
Medical Director, DME MAC Jurisdiction A

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

Stacey V. Brennan, MD, FAAFP
Medical Director, DME MAC Jurisdiction B

Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC Jurisdiction D
Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers’ Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)

MLN Matters Number: MM6421 Revised
Related Change Request (CR) #: 6421
Related CR Release Date: December 16, 2010
Effective Dates: Phase 1 – October 1, 2009
Related CR Transmittal #: R823OTN
Implementation Date: Phase 1 – October 5, 2009
Phase 2 – To be announced

Note: This article was revised on August 15, 2011, to delete chiropractors from the list of providers on page 2 who may order and/or refer. All other information remains the same. In the near future, CR6421 will be revised to remove chiropractors from that CR’s list of providers who may order and/or refer. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will provide providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The “To Be Announced” implementation and effective dates in this article are the correct dates.

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

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

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

The providers who can order/refer are:
- Doctor of Medicine or Osteopathy;
- Dental Medicine;
- Dental Surgery;
- Podiatric Medicine;
- Optometry;
- Physician Assistant;
- Certified Clinical Nurse Specialist;
- Nurse Practitioner;
- Clinical Psychologist;
- Certified Nurse Midwife; and
- Clinical Social Worker.

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

Key Points
- **During Phase 1 (October 5, 2009- until further notice):** When a claim is received, Medicare will determine if the ordering/referring provider is required for the billed service. If the ordering/referring provider is not on the claim, the claim will continue to process. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and is eligible to order/refer. If the ordering/referring provider is not in PECOS or is in PECOS but is not of the type/specialty to order or refer, the claim will also continue to process.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a warning message on the Common Electronic Data Interchange (CEDI) GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will not receive a warning and will not know that the claim did not pass these edits.
- **During Phase 2 (Start Date to Be Announced):** If the ordering/referring provider is not on the claim, the claim will not be paid. If the ordering/referring provider is on the claim, Medicare will verify that the ordering/referring provider is in PECOS and eligible to order and refer. If the ordering/referring provider is not in PECOS or is in PECOS but is not of the specialty to order or refer, the claim will not be paid. It will be rejected.
  1. If the DMEPOS supplier claim is an ANSI X12N 837P standard electronic claim, the DMEPOS supplier will receive a rejection message on the CEDI GenResponse Report.
  2. If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.
- **In both phases,** Medicare will verify the NPI and the name of the ordering/referring provider reported on the ANSI X12N 837P standard electronic claim against PECOS.
When furnishing names on the paper claims, be sure not to use periods or commas within the name. Hyphenated names are permissible.

Providers who order and refer may want to verify their enrollment or pending enrollment in PECOS. You may do so by:

- Using Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) For more information, regarding PECOS enrollment go to http://www.cms.gov/MedicareProviderSupEnroll/Downloads/Instructionsforviewingpractitionerstatus.pdf on the CMS website. If no record is displayed, you do not have an enrollment record in PECOS.
- I don’t have an enrollment record. What should I do? Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see “Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners” at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhyNonPhys_FactSheet_ICN903764.pdf on the CMS website.

Additional Information

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

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R823OTN.pdf on the CMS website.

Provider Action Needed

Change Request (CR) 7212 instructs Medicare DME MACs to prohibit separate payment for repairs to capped rental items during the rental period. The rental period is not to exceed 13 continuous months. However, payment for all maintenance, servicing, and repair of capped rental equipment is included in the allowed rental payments. Under no circumstances will Medicare pay for these services prior to the end of the 13-month capped rental period. Suppliers of capped rental items need to be aware of this issue as it impacts maintenance and servicing of DME for Medicare beneficiaries as described in this article.

Key Points of CR7212

- Claims for replacement parts for capped rental items billed during the 13-month capped rental period with the “RB” modifier, including parts submitted using code E1399, will be denied.
- Claims for repairs that are billed with the Healthcare Common Procedure Coding System (HCPCS) code K0739 for the labor associated with repairs of capped rental equipment during the 13-month capped rental period will be denied.
- In denying these claims, DME MACs will use the following Claim Adjustment Reason Code (CARC), and Remittance Advice Remark Codes (RARCs) messages for claims denied or rejected for DME repairs during the capped rental period:
  - CARC 97: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. NOTE: refer to the 835 healthcare policy identification segment (loop 2110 service payment information ref), if present.”
  - RARC MA13: “Alert: You may be subject to penalties if you bill the patient for amounts not reported with the Patient Responsibility (PR) group code.” and
  - RARC N211: “Alert: You may not appeal this decision”

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.

For complete details regarding this CR please see the official instruction (CR 7212) issued to your Medicare DME MAC. That instruction may be viewed by going to http://www.cms.gov/Transmittals/downloads/R901OTN.pdf on the Centers for Medicare and Medicaid Services (CMS) website. To review the recent 2010 report from the Office of the Inspector General on this issue, you may go to http://oig.hhs.gov/oei/reports/oei-07-08-00550.pdf on the Internet.
Implementation of New Reasonable Useful Lifetime (RUL) Policy for Stationary and Portable Oxygen Equipment

MLN Matters® Number: MM7213  
Related Change Request (CR): 7213  
Related CR Release Date: April 8, 2011  
Effective Date: May 8, 2011  
Related CR Transmittal #: R871OTN  
Implementation Date: May 8, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs) for portable and stationary oxygen equipment for Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 7213 implements changes to address situations in which a beneficiary has both portable and stationary oxygen equipment and the RUL for one piece of equipment expires before the RUL for the other piece of equipment has been reached.

Background
CR 7213 results in systems changes to establish new RUL policies for instances where the beneficiary has both portable and stationary oxygen equipment and the RUL for one piece of equipment expires before the RUL for the other piece of equipment has been reached. In most cases, a beneficiary who requires both stationary and portable oxygen will have developed the need for both stationary and portable oxygen at the same time, will have received their stationary and portable oxygen equipment at the same time, and will be in a situation where the RUL for the stationary oxygen equipment ends at the same time that the RUL for the portable oxygen equipment ends. At the end of the RUL, the beneficiary can elect to obtain new oxygen equipment.

Payment for portable oxygen equipment under Medicare is made as an add-on to the monthly payment amount for oxygen and oxygen equipment, which includes payment for stationary equipment, stationary oxygen contents, and portable oxygen contents. As a general rule, the same supplier that furnishes the stationary oxygen equipment to a beneficiary and receives the monthly payment for oxygen and oxygen equipment should also be furnishing the portable oxygen equipment to that beneficiary since a component of the payment for portable oxygen (portable oxygen contents) is included in the monthly payment amount for oxygen and oxygen equipment. A supplier of either stationary oxygen equipment or portable oxygen equipment that has furnished the equipment for 36 months of continuous use must continue to furnish the oxygen equipment to the beneficiary for the remainder of the RUL. Under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program, this responsibility does not transfer to a contract supplier if the supplier is not awarded a contract. When the RUL for oxygen equipment ends and the beneficiary elects to obtain replacement oxygen equipment, the replacement equipment must be furnished by a contract supplier and cannot be furnished by a non-contract supplier.

At the start of a competitive bidding program, a supplier that is not awarded a contract for furnishing oxygen and oxygen equipment under the program may elect to continue or may be required to continue furnishing oxygen and oxygen equipment to beneficiaries they are currently serving:

1. They may elect to be a grandfathered supplier for oxygen and oxygen equipment that has not yet reached the 36-month rental cap for all of their current customers who are Medicare beneficiaries residing in a DMEPOS Competitive Bidding Area (CBA); or
2. They are required to continue furnishing oxygen and oxygen equipment for which they received the 36th rental payment prior to the start of the program for the remainder of the RUL established for the equipment.

Key Points of CR7213
The following rules apply in situations where the beneficiary is using both stationary and portable oxygen equipment with different RUL end dates.

- When the RUL of a beneficiary’s portable oxygen equipment differs from the RUL of the beneficiary’s stationary oxygen equipment, the RUL of the stationary oxygen equipment shall govern the application of RUL-based rules and processes for both types, stationary and portable, of oxygen equipment.
- Until such time, as the end date of the RUL of the stationary oxygen equipment is reached, the supplier must continue to furnish both the portable and stationary oxygen equipment.
- If the end date of the RUL of the portable oxygen equipment precedes the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen equipment is adjusted (extended) to coincide with the end date of the RUL of the stationary oxygen equipment.
- If the end date of the RUL of the portable oxygen equipment follows the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen equipment is adjusted (shortened) to coincide with the end date of the RUL of the stationary oxygen equipment.
- When the end date of the RUL of the stationary oxygen equipment occurs, the beneficiary may elect to obtain replacement of both the stationary and the portable oxygen equipment.
- If the beneficiary elects to obtain replacement of the stationary and the portable oxygen equipment, both types of oxygen equipment must be replaced at the same time.
When the stationary and the portable oxygen equipment are replaced, a new 36-month rental period and new RUL is started for both the replacement stationary oxygen equipment and the replacement portable oxygen equipment.

Beginning January 1, 2011, a beneficiary who resides in a DMEPOS CBA may obtain replacement of both the stationary and portable oxygen systems only from a contract supplier having a competitive bidding contract for the CBA in which the beneficiary permanently resides.

A grandfathered supplier for oxygen and other grandfathered equipment as of January 1, 2011, who has continued to furnish such equipment that has not yet reached the 36-month rental cap, does not qualify to furnish replacement equipment once the end date of the RUL of the stationary equipment is reached, if the beneficiary resides in the CBA when the end of the RUL has been reached (unless the status of the grandfathered supplier has changed to a contract supplier for the current round of the DMEPOS competitive bidding program).

Additional Information

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

For complete details regarding this CR please see the official instruction (CR 7213) issued to your Medicare RHHI or DME MAC. That instruction may be viewed by going to http://www.cms.gov/Transmittals/downloads/R871OTN.pdf on the CMS website.

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

MLN Matters® Number: MM7306 Revised
Related Change Request (CR) #: 7306
Related CR Release Date: June 22, 2011
Effective Date: July 1, 2011, except October 1, 2011, for claims submitted to DME MACs
Related CR Transmittal #: R908OTN
Implementation Date: July 5, 2011, except October 3, 2011, for claims submitted to DME MACs

Note: This article was revised on June 23, 2011, to reflect a revised CR7306, which was issued on June 22. In this article, the effective and implementation dates have been revised for claims handled by DME MACs. Also, the CR release date, transmittal number and the Web address for accessing CR7306 have been revised. All other information is the same.

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 (DME MACs), and Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs)).

What You Need to Know

This article is based on Change Request (CR) 7306, which instructs Medicare contractors about additional business requirements that are necessary to complete the implementation of the PWK segment scheduled for July 2011 (except October 2011 for DME MACs) under CR 7041. An article related to CR 7041 is available at http://www.cms.gov/MLNMattersArticles/downloads/MM7041.pdf on the CMS website. Of significance to the provider community is a change whereby Medicare contractors will only return an incomplete/incorrect fax/mail cover sheet, when such is received. In CR 7041, the attached data was to be returned as well, but that is no longer the case. Also, note that CR 7306 requires your contractor to mask any Protected Health Information ( PHI) on the fax/cover sheet returned to you.

In addition, the following changes will result from CR 7306:

- In PWK02, Medicare contractors will only use values BM and FX and will communicate that via the companion document. Other values will be accepted only in CMS-approved electronic claims attachment pilots based on agreements with willing trading partners.
Medicare contractors will have the ability to accept the PWK02 value of EL for those contractors in a CMS-approved electronic claims attachment pilot.

Contractors will allow seven calendar “waiting” days (from the date of receipt) for additional information to be submitted when the PWK02 value is EL.

**Be sure your staffs are informed of this change.**

### Additional Information


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

### Pharmacy Billing for Drugs Provided “Incident To” a Physician Service

**MLN Matters® Number:** MM7397 *Revised
**Related Change Request (CR) #:** 7397
**Related CR Release Date:** August 5, 2011
**Effective Date:** October 1, 2011
**Related CR Transmittal #:** R2271CP
**Implementation Date:** October 1, 2011

*Note:* This article was revised on August 9, 2011, to reflect the revised CR7397 issued on August 5. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.

### Provider Types Affected

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

### What You Should Know

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

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

### Background

**Pharmacies Billing Drugs**

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

**Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.**

**In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician’s service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.**

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

### When Drugs May Not be Billed by Pharmacies to Medicare Part B

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

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

### Payment Limits

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

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

### Additional Information


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.

The following manual sections regarding billing drugs and biological and “incident to” services may be helpful:
Prospective Billing for Refills of DMEPOS Items Provided on a Recurring Basis

MLN Matters® Number: MM7452
Related Change Request (CR) #: 7452
Related CR Release Date: July 1, 2011
Effective Date: August 2, 2011
Related CR Transmittal #: R378PI
Implementation Date: August 2, 2011

Provider Types Affected
Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for DMEPOS items and supplies that are provided on a recurring basis.

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

Background
For DMEPOS items and supplies that are provided on a recurring basis, billing must be based on prospective, not retrospective use. The following scenarios are illustrative of this concept:

- **Scenario 1:** The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order, delivers 100 units and bills the claim with a date of service as the date of delivery indicating 100 units of enteral nutrition. This is an example of prospective billing and is acceptable.

- **Scenario 2:** The treating physician writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order and delivers 100 units. A claim is not billed. At the end of the month, the supplier determines that the beneficiary used 90 units for the month and delivers 90 units to replace the nutrient used. A claim is then submitted with a date of service as the date of delivery indicating 90 units of enteral nutrition. This is an example of retrospective billing and is not acceptable.

Additional Information

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

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

MLN Matters® Number: MM7454
Related Change Request (CR) #: 7454
Related CR Release Date: June 24, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2246CP
Implementation Date: October 3, 2011

Provider Types Affected
All Medicare providers and suppliers submitting claims to Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), Carriers, A/B Medicare Administrative Contractors (MAC) and Durable Medical Equipment (DME) MACs are affected by this article.

Provider Action Needed
This article, based on Change Request (CR) 7454, informs you that the Centers for Medicare & Medicaid Services (CMS) is providing its annual reminder of the ICD-9-CM update that is effective for the dates of service and discharges on or after October 1, 2011 (effective for discharges on or after October 1, 2011, for institutional providers). Please be sure to inform your staffs of these updates.

Background
ICD-9 Information
The ICD-9-CM codes are updated annually. Effective since October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare contractors and MACs, with the exception of ambulance claims (specialty type 59).

CMS posts the new, revised and discontinued ICD-9-CM diagnosis codes annually at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage) on the CMS website. The updated diagnosis codes are effective for dates of service and discharges on and after October 1. You
may view the new updated codes at this site in June. You may also visit the National Center for Health Statistics (NCHS) website at [http://www.cdc.gov/nchs/icd.htm](http://www.cdc.gov/nchs/icd.htm) on the Internet. The NCHS will post the new ICD-9-CM Addendum on their website in June. You are also encouraged to purchase a new ICD-9-CM book or CD-ROM annually.

**International Classification of Diseases, Tenth Revision (ICD-10) Information**

CMS has posted a list of 2011 ICD-10-CM code descriptions in tabular order (the order they appear in the code book) at [http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMS.asp](http://www.cms.gov/ICD10/11b1_2011_ICD10CM_and_GEMS.asp) on the CMS website. The tabular order version of ICD-10-CM will assist those who wish to identify a range of codes and make certain they have correctly identified all codes within the range. In addition, a list of 2012 ICD-10-PCS codes is at [http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp](http://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp) on the CMS site. The 2012 iCD-10-CM list should be posted later this year and its posting will be conveyed via listserv notices.

**Additional Information**


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

**Medical Policy**

**Upgrades to Group 2 Power Operated Vehicles (K0806-K0808) and Group 4 Power Wheelchairs (K0868-K0886)**

Recent revisions to the Power Mobility LCD eliminating Least Costly Medically Necessary Alternative classified the denials for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) as statutorily non-covered. This determination caused the unintended consequence of making these items ineligible for the Advanced Beneficiary Notice (ABN) upgrade process. The LCD and Policy Article are being revised to indicate that Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are considered durable medical equipment but are not reasonable and necessary. This change will be effective for dates of service on or after June 1, 2011.

In addition to capabilities that allow Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) to be used in the home, they also have certain performance characteristics that are not reasonable and necessary for use in the home such as (not all-inclusive):

- Robust frames
- Motors with increased torque/power
- Suspensions with enhanced vibration-dampening or obstacle climbing capabilities

The revised Power Mobility Devices LCD and related policy article will reflect that claims for Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) will be denied as not reasonable and necessary. As a result, Group 2 POVs (K0806-K0808) and Group 4 PWCs (K0868-K0886) are eligible for the ABN upgrade provisions as set out in the recently published bulletin article on the use of upgrade modifiers as a result of changes due to elimination of least costly alternative. “Revised - Use of Upgrade Modifiers” was posted to DME MAC Jurisdiction C’s web page on January 18, 2011.

Refer to the LCD, Policy Article, and Supplier Manual for additional information on upgrades and Power Mobility devices.

The Power Mobility Devices LCD and Policy Article revisions will be published in the near future.

**LCD and Policy Article Revisions**

**Summary for May 12, 2011**

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

**Oral Anticancer Drugs**

Policy Article

*Revision Effective Date: 06/01/2011*

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**

*Added:* Preamble language

*Revised:* Supply fee guidelines for additional billing of Q0511

**Oral Antiemetic Drugs** (Replacement for Intravenous Antiemetics)

Policy Article

*Revision Effective Date: 06/01/2011*

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**

*Revised:* Supply fee guidelines for additional billing of Q0511

**Immunosuppressive Drugs**

Policy Article

*Revision Effective Date: 06/01/2011*

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**

*Added:* Preamble language

*Revised:* Supply fee guidelines for additional billing of Q0510, Q0511

**Power Mobility Devices**

LCD

*Revision Effective Date: 06/01/2011*

**INDICATIONS AND LIMITATIONS OF COVERAGE:**

*Added:* Denial statement for Group 2 POVs

*Deleted:* X modifier use with Group 4 PWCs
Revised: Requirements for the detailed product description
Added: Clarification of 7-element order requirements

Power Mobility Devices
Policy Article
Revision Effective Date: 06/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Benefit category statement
Added: Statutory reference for 7-element order requirements
Removed: Noncoverage statement for Group 2 POVs and Group 4 PWCs.

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

A webinar to enhance your understanding will be coming soon.

Oral Appliance for OSA – E0486 Custom Fabricated – Coding and Utilization Guidelines

Code E0486 describes a custom fabricated oral appliance used for the treatment of obstructive sleep apnea.

E0486 ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT

Effective for claims submitted on or after September 1, 2011, the only products that may be billed using code E0486 are those that have undergone Coding Verification Review by the Pricing, Data Analysis, and Coding (PDAC) Contractor and that are listed in the DMECS Product Classification List on the PDAC website.

Questions concerning the coding of these products should be referred to the PDAC. For additional information about coverage, refer to the Oral Appliances for the Treatment of Obstructive Sleep Apnea LCD and policy Article at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

LCD and Policy Article Revisions
Summary for May 26, 2011

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

Knee Orthoses
LCD
Revision Effective Date: 07/01/2011
ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-9 codes 340.91 and 340.92 for L1832, L1843 - L1846

Oral Appliances for Obstructive Sleep Apnea
LCD
Revision Effective Date: 09/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement
CODING GUIDELINES:
Added: PDAC review requirement for E0486

Policy Article
Revision Effective Date: 09/01/2011
NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble
Added: Benefit category statement
CODING GUIDELINES:
Added: PDAC review requirement for E0486

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

LCD and Policy Article Revisions
Summary for June 23, 2011

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

Glucose Monitor
Policy Article
Revision Effective Date: 07/01/2011
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Preamble language
Added: Institutional use glucose monitor benefit language
CODING GUIDELINES:
Added: Definitions for glucose monitors E0607, E2100, E2101
Added: Instructions for billing “kits” with initial issue of glucose monitors
Added: Bundling table

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

LESSONS LEARNED:
J7626 Widespread Probe Review

CGS’s Medical Review staff recently completed a post payment service-specific probe review of HCPCS Code J7626 (Budesonide Inhalation Solution) claims. This review was conducted because data analysis revealed that, when compared to national allowed charges, Jurisdiction C’s allowed dollars for HCPCS Code J7626 was significantly above expected amounts. Additionally, the nebulizer policy group ranked #3 in total CERT errors and #7 in CERT allowed dollars errors in Jurisdiction C.

The sample consisted of 100 randomly selected claims from a universe of claims submitted by all suppliers billing HCPCS code J7626. Sample claims were submitted by sixty-seven different suppliers. Sample paid dates were October 1, 2010 through December 31, 2010.
CGS did not receive records for 5 of the claims in the sample. Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

CGS did receive records for 95 of the claims in the sample. Documentation however, for 71 of these 95 claims, provided insufficient information to verify that Medicare coverage criteria were met for payment of nebulizer drug therapy. A summary of findings is provided below.

### Delivery Documentation

The delivery documentation was checked to verify that it met the following policy requirements:

- The documentation included the name of the beneficiary and a detailed description of the item(s) provided;
- The date of delivery (if the supplier personally delivered the item) or the date shipped (if the supplier used a shipping service) matched the date of service billed on the claim; and
- Documentation included either a signature to confirm delivery or a copy of a tracking document that confirmed delivery.

#### Findings regarding delivery documentation were as follows:

- **16 claims**: The delivery/shipping date did not match the date of service billed;
- **15 claims**: Document did not provide a detailed list of what was delivered;
- **7 claims**: The name of the beneficiary was not on the document;
- **7 claims**: The supplier did not provide delivery documentation; and
- **7 claims**: Documentation did not include a signature or a tracking slip to confirm delivery.

Suppliers are reminded that, if items are personally delivered to a beneficiary, the date of service billed must be the actual date of receipt. Therefore, when the beneficiary calls in a refill request one day but picks the drug up on a subsequent day, the date of service billed must be the pick-up date. In situations where the supplies are delivered via a shipping service, the date of service billed must be the shipping date.

Some delivery documents included a prescription (RX) number instead of listing the name of the drug being supplied. Consequently, the reviewer was unable to verify that the supplier correctly billed the drug that was provided. When a Medicare contractor requests delivery documentation and the supplier’s practice is to list a number instead of the drug’s name, it is recommended that the supplier also send a reference key such as a copy of the prescription label so the reviewer can match the number to the HCPCS code billed.

### Detailed Written Order

The detailed written order was checked for the following elements:

- Beneficiary’s name;
- List of all separately billed items to be dispensed;
- Refill instructions;
- Treating physician’s signature;
- Physician’s signature date (personally entered by physician);
- Start date of the order (if different from the signature date);
- Type of solution to be dispensed was described either by:
  - The name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container or
  - The name of the drug and the number of milligrams/grams of drug in the dispensed solution and the volume of solution in that container; and
- Administration instructions specified the amount of solution and the frequency of use.

Claim history was also checked to make sure that the written order was obtained prior to billing and the signature was examined to make sure it met CMS signature requirements.

#### The following deficiencies were found in regards to detailed written orders:

- **28 claims**: The detailed written order was missing required elements;
- **4 claims**: There was no detailed written order in the file;
- **4 claims**: The supplier billed the claims prior to receipt of the detailed written order;
- **3 claims**: The detailed written order was on a supplier form with a pre-printed list of multiple compressors and supplies checked. The form did not allow the physician to individualize the order for each specific beneficiary;
- **2 claims**: The physician’s signature was missing or illegible;
- **2 claims**: The orders were blackened and illegible;
- **1 claim**: A signature stamp was used instead of the physician personally signing the order; and
- **1 claim**: The detailed written order expired prior to the date of service billed.

By far, the most common error involving detailed written orders was that the order was missing elements that are required by policy. Chapter Three (http://www.cgsmedicare.com/jc/pubs/pdf/Chpt3.pdf) of the DME MAC Jurisdiction C Supplier Manual contains comprehensive instructions regarding the required elements for all DMEPOS detailed written orders as well as additional requirements for medication orders. The Nebulizer LCD (LCD L5007) (http://www.cms.gov/medicare-coverage-database/indexes/lcd-list.aspx?Cntnrct=140&name=CIGNA+Government+Services+(18003,+DME+MAC)&ContrNum=18003&CntnrctType=DME#ResultsAnchor) also includes additional specifications for a nebulizer drug order.

Suppliers are also reminded that they should not provide stock order forms to physicians that list a variety of equipment, accessories and supplies in a format (see Example A) that does not allow the physician to individualize the order for each beneficiary. The form must be designed in a way (see Example B) that allows the physician to only order the items that are medically necessary.
Dispensing Order

If the drug was dispensed prior to obtaining a detailed written order, suppliers were asked to provide a copy of the dispensing order (preliminary written order or proof of a verbal/telephone order). The review revealed one instance where the supplier dispensed the Budesonide without written documentation of a dispensing order and prior to receipt of the completed detailed written order.

Refill Request

Refill requests were reviewed to make sure that suppliers were not automatically providing refill without proof that the beneficiary or a caregiver authorized the refill. The reviewer also checked to make sure the request for refill and delivery/shipping dates fell within Medicare’s time frame specifications.

The following errors were noted in regards to refill requests:

- 6 claims: There was no refill request in the file;
- 2 claims: The refill request was missing a list of items to be refilled; and
- 1 claim: The refill request was received more than approximately 7 days before the previous supply was expected to be exhausted.

Medical Necessity for Nebulizer Drug Therapy

Suppliers were asked to submit medical records to support that the medical necessity coverage criteria listed in the LCD were met. The findings were as follows:

- 24 claims: No medical records were provided;
- 7 claims: The medical records did not confirm the continued use of the medication or address the medical necessity for the drug in the ongoing medical management of the pulmonary condition;
- 6 claims: The medical records did not confirm the medical necessity for administering the drug for the management of obstructive pulmonary disease;
- 6 claims: The author’s signature was missing or illegible; and
- 2 claims: None of the records were concurrent (within approximately the 12 preceding months) with the date of service under review.

LCD and Policy Article Revisions

Summary for July 14, 2011

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

Wheelchair Options and Accessories LCD

Revision Effective Date: June 1, 2011
DOCUMENTATION REQUIREMENTS:
Revised: Language for detailed product description.

Wheelchair Seating LCD

Revision Effective Date: June 1, 2011
DOCUMENTATION REQUIREMENTS:
Revised: Language for detailed product description.

LCD Revisions Released for Comment - Automatic External Defibrillators, Pneumatic Compression Devices, and Suction Pumps

The Centers for Medicare and Medicaid Services (CMS) assigned to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the task of developing local coverage determinations (LCDs) for processing and reviewing Medicare claims for Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS). The DME MACs are proposing revisions to three LCDs: Automatic External Defibrillators, Pneumatic Compression Devices, and Suction Pumps.

A webinar to enhance your understanding will be coming soon.
These three LCDs are revisions to existing LCDs; therefore not all of the material in each policy is new. The major revisions are summarized below; however, each LCD should be completely reviewed in the preparation of comments.

**Automatic External Defibrillator LCD changes**
- Revised coverage criteria for wearable (K0606) and non-wearable (E0617) defibrillators
- Added definition for myocardial infarction to maintain consistency with national coverage determination for implantable defibrillators
- Revised covered diagnosis code list

**Pneumatic Compression Devices (PCD) LCD changes**
- Added coverage for peripheral arterial disease using arterial insufficiency devices (E0675)
- Revised coverage criteria for PCDs E0650, E0651 and E0652

**Suction Pumps LCD changes**
- Added not reasonable and necessary statement for wound suction pumps (K0743) and related supplies (K0744-K0746)
- Added coverage criteria for gastric suction (E2000)

We are soliciting comments on these draft policies from physicians, manufacturers, suppliers and other professionals involved in the ordering or provision of these items. We recommend that you distribute these draft policies to selected members of your organization for review and comment. If you disagree with any aspect of a policy, you should be very specific in your comment and, if possible, offer an alternative. You should provide a clinical rationale for your position including references from the published clinical literature (e.g. standard textbooks, peer-reviewed journals, etc.). We encourage a written response if you agree with this policy. **If you are providing comments on more than one LCD, please provide separate comments for each policy with the policy indicated in the subject line of the submission.**

All comments will be collected at a single point of contact. Please submit your comments electronically to the DME MAC medical directors at the e-mail address listed no later than September 23, 2011. Comments may also be submitted hardcopy although e-mail is preferred.

- Paul J. Hughes, MD  
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A joint DME MAC public meeting will be held on August 30, 2011 in Baltimore, MD. Interested parties from any DME MAC jurisdiction may attend this public meeting. This meeting is for oral presentations only. Meeting minutes are not taken and there is no Question and Answer component to the meeting. In order for comments to be considered, they must be presented in writing through the formal comment process. Advance registration is required. Information regarding this meeting will be posted in the near future on each DME MAC website.

**Important Reminder:** Suppliers are cautioned not to make any changes based upon the information contained in these draft documents. Drafts are often substantially revised based upon the comments received. When all comments have been reviewed, revisions will be considered. The final policies will be published in the CMS Medicare Coverage Database and on individual DME MAC websites, allowing for adequate notice before the policies’ effective date.

Thank you for your participation in our policy revision process.

Refer to each DME MAC website for additional information about policy development and copies of the draft LCDs.


**LCD and Policy Article Revisions**

**Summary for August 25, 2011**

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

**Glucose Monitors**

**LCD**

**Revision Effective Date:** 08/02/2011  
**INDICATIONS AND LIMITATIONS OF COVERAGE:**
- *Revised:* Refills information  
**DOCUMENTATION REQUIREMENTS:**
- *Added:* Refills documentation information

**Nebulizers**

**LCD**

**Revision Effective Date:** 08/02/2011  
**INDICATIONS AND LIMITATIONS OF COVERAGE:**
- *Revised:* Refills information  
**DOCUMENTATION REQUIREMENTS:**
- *Added:* Refills documentation information  
- *Deleted:* Statement requiring routine prescription every 12 months.

**Policy Article**

**Revision Effective Date:** 08/02/2011  
**NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES:**
- *Added:* Noncoverage statement for drugs not administered through DME  
- *Added:* Noncoverage statement for disposable equipment

**Negative Pressure Wound Therapy Pumps**

**LCD**

**Revision Effective Date:** 10/01/2011  
**INDICATIONS AND LIMITATIONS OF COVERAGE AND MEDICAL NECESSITY:**
- *Added:* Definition for NPWT systems and wound suction systems  
- *Revised:* A6550 quantities statement to be consistent with the HCPCS narrative all-inclusive definition.
Revised: Untreated osteomyelitis exclusion
Added: Reference statement for wound suction pumps and associated dressings pointing to Suction Pump LCD.
Revised: Supplies refill monitoring and dispensing instructions. (Effective 08/02/2011)

DOCUMENTATION REQUIREMENTS:
Revised: Preamble
Added: Statement about comparison of wound measurements
Added: Statement about initial inpatient start date.
Added: Statement about documentation for treatment past the initial 4-months
Revised: Length of need for the prescription
Revised: Appeals information for extended months of treatment
Added: Refill Documentation guidelines. (Effective 08/02/2011)

Policy Article
Revision Effective Date: 10/01/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Noncoverage statement for disposable items

CODING GUIDELINES:
Added: System statements for NPWT
Added: Coding instructions for nondurable (disposable) pumps and related supplies
Clarified: A6550 as dressing allowance.

Oxygen and Oxygen Equipment LCD
Revision Effective Date: 10/01/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:
Added: PSG and HST testing guidance.
Added: CR7452 refill requirements (effective 08/02/2011)

HCPCS CODES AND MODIFIERS:
Added: Q0 modifier

DOCUMENTATION REQUIREMENTS:
Revised: Prescription requirements
Clarified: Documentation requirements form NCD 240.2 and PIM Ch. 5
Added: CR7452 refill requirements effective (08/02/2011)
Added: Cluster Headache section

Policy Article
Revision Effective Date: 10/01/2011

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: CR7213 reasonable useful lifetime provisions (effective 05/08/2011)
Added: Reference to CR7452 refill requirements LCD provision to oxygen contents (effective 08/02/2011)

CODING GUIDELINES:
Added: Cluster headache oxygen contents coding instruction

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea LCD
Revision Effective Date: 08/02/2011

INDICATIONS AND LIMITATIONS OF COVERAGE:
Revised: Refills information

DOCUMENTATION REQUIREMENTS
Added: Refills documentation information

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

A webinar to enhance your understanding will be coming soon.

Power Mobility Device
Face-to-Face Examination Checklist

MLN Matters® Number: SE1112
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected
This Special Edition (SE) MLN Matters® article is intended for physicians or treating practitioners who prescribe a Power Mobility Device (PMD) for Medicare beneficiaries. (In addition to a physician; a physician assistant, nurse practitioner, or clinical nurse specialist may order a PMD.) The article should also be of interest to Durable Medical Equipment (DME) suppliers who submit claims to DME Medicare Administrative Contractors (DME MACs) for such equipment.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) is issuing this article as solely an educational guide to improve compliance with documentation requirements for the face-to-face examination that occurs prior to the physician or treating practitioner ordering a PMD for their Medicare patients. The article presents a checklist, which is a tool that providers may wish to use for this examination, in addition to some helpful tips to help providers and suppliers avoid denial of their PMD claims. The use of this guide is not mandatory and does not ensure Medicare payment for a PMD, even if signed and dated.

Background
Power wheelchairs and power operated vehicles (also known POVs or scooters) are collectively classified as Power Mobility Devices (PMDs) and are covered under the Medicare Part B benefit. CMS defines a PMD as a covered item of DME that includes a power wheelchair or a POV that a beneficiary uses in the home. Effective May 5, 2005, CMS revised national coverage policy to create a new class of DME identified as Mobility Assistive Equipment (MAE), which includes a continuum of technology from canes to power wheelchairs.

In addition to the prescription for the PMD, the physician or treating practitioner must provide the supplier with supporting documentation consisting of portions of the medical record essential for supporting the medical necessity for the PMD in the beneficiary’s home. In order to document the need for a PMD there are a few specific statutory requirements that must be met before the prescription is written:
1. An in-person visit between the ordering physician and the beneficiary must occur. This visit must document the decision to prescribe a PMD.

2. A medical evaluation must be performed by the ordering physician. The evaluation must clearly document the patient’s functional status with attention to conditions affecting the beneficiary’s mobility and their ability to perform activities of daily living within the home. This may be done all or in part by the ordering physician. If all or some of the medical examination is completed by another medical professional, the ordering physician must sign off on the report and incorporate it into their records.

3. Items 1 and 2 together are referred to as the face-to-face exam. Only after the face-to-face examination is completed may the prescribing physician write the prescription for a PMD. This prescription has seven required elements and is referred to as the seven-element order which must be entered on the prescription only by the physician.

4. The records of the face-to-face examination and the seven-element order must be forwarded to the PMD supplier within 45 days of the completion of the face-to-face examination.

5. CMS’ National Coverage Determination requires consideration as to what other items of mobility assistive equipment (MAE), e.g., canes, walkers, manual wheelchair, etc., might be used to resolve the beneficiaries mobility deficits. Information addressing MAE alternatives must be included in the face-to-face medical evaluation.

CMS offers a checklist that providers may wish to use in the examination and documentation process and can be found in the ‘Attachment’ section at the end of this article. The checklist contains the information that is essential for Medicare to determine the medical necessity of the PMD. Please note, the checklist contained in this article is a guide and does not replace the underlying medical records. The checklist outlines the information that is essential for Medicare to have in determining whether payment should be made for a PMD. It is provided for educational purposes and serves to help providers understand the types of information which Medicare believes is critical for providers to document the patient’s medical need in the home and that the device can be used safely.

The evaluation should be tailored to the individual patient’s conditions. The medical history should contain a well-documented description 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.

**Tips to Avoid Denial of PMD Claims**

Medical records should contain enough information to support the coverage for a PMD. Currently, audits show medical records commonly lack documentation that justifies the need for payment.

The medical record must contain sufficient information to show that the coverage criteria for a PMD are met. This information must be directly related to the patient’s use of a PMD. Key items to be addressed are:

- Why does the patient require the use of a PMD in the home to safely and effectively accomplish Activities of Daily Living (ADLs)?
  - Examples of ADLs include but are not limited to bathing, grooming, dressing, toileting.
  - What are important medical history factors that demonstrate the patient’s mobility limitations?
- Do the physical examination findings support the patient’s claimed functional status (mobility level)?
- Physical Examination (PE): The information provided in the PE must support the pertinent history above. The information must not be recorded in vague and subjective terms (e.g. weak, breathless, tired, etc), but instead must provide quantifiable, objective measures or tests of the abnormal characteristic (e.g. range of motion; manual muscle test scores; heart rate/respiratory rate/pulse oximetry). Each medical record is expected to be individualized to the unique characteristics of the patient. Included in all exams must be a detailed description of the patient’s observed ability or inability to transfer and/or walk. Examples of other patient physical findings that would commonly be relevant to describe medical need for and ability to use a PMD include:
  - Height and weight;
  - Limb abnormalities;
  - Strength, tone, coordination, reflexes, balance;
  - Heart rate, blood pressure, respiratory rate (at rest and with exertion);
  - Joint swelling, range of motion, erythema, subluxation;
  - Description of limb loss; and
  - Cardiopulmonary exam
- If the patient is thought to require a PMD due to respiratory illness or injury:
  - Does the patient use home oxygen? If yes, what is the frequency, duration, delivery system, and flow rate denoted? How far does the patient report that she/he can walk or self-propel a manual wheelchair before becoming short of breath (with best oxygenation provided)? Describe the ADLs that make him/her short of breath in the home (with best oxygenation provided) and the interventions that palliate them. How have these signs/symptoms changed over time?
- If the patient is thought to require a PMD due to cardiovascular illness or injury:
  - Specifically, describe any clinically significant increased heart rate, palpitations, or ischemic pain that occurs or worsens when the patient attempts or performs ADLs within the home (with best oxygenation provided)? What palliates these signs/symptoms? How far does the patient report that she/he can walk or self-propel a manual wheelchair before experiencing these signs/symptoms? How have these signs/symptoms changed over time?
- If the patient is thought to require a PMD due to neuromusculoskeletal illness or injury or malformed body member:
Describe the patient’s impairments. For example, does the patient exhibit joint/bone signs/symptoms, changes in strength, coordination or tone? How do these signs/symptoms relate to the patient’s functional state and the ability to perform ADLs in specific? How far does the patient report that she/he can walk or self-propel a manual wheelchair before these signs/symptoms interrupt that activity? How have these signs/symptoms changed over time?

Illustrative Example of Medical Record Documentation

This entry may result in a claim DENIED:
Mr. Smith is a male, age 72, with Chronic Obstructive Pulmonary Disease (COPD) who over the last few weeks has been having more Shortness of Breath (SOB). He states he is unable to walk for me today because he is too tired. Therefore he needs a PMD.

Instead consider an entry with this level of detail and support:
Mr. Smith is a 72 yo male with COPD, worsening gradually over the past year despite compliant use of XYZ meds, nebulizers and rescue inhalers. PFT’s (attached) demonstrate the decline in lung function over the last 12 months. Now with the constant use of 2-3L NC O2 at home for the last month, he still can no longer walk to the bathroom, about 30 feet from his bed without significant SOB and overall discomfort. The kitchen is further from his bed. He says his bed/bath doorways and halls are wide enough for a scooter that will bring him to his toilet, sink and kitchen, all of which are on the same floor.

VS 138/84, Ht rate 88 RR 16 at rest on 3L NC Vision- sufficient to read newspaper with glasses on Cognition- OX3. Able to answer my questions without difficulty.

Ambulation – Sit to stand was done without difficulty. Patient attempted to ambulate 50’ in hallway, but needed to stop and rest 2 x’s before he could accomplish. HR at first stop point (about 25’) was 115 and RR was 32. Patient became slightly diaphoretic. Lung exam – Hyperresonant percussion and distant breath sounds throughout. Occ wheezes. Neuro- Hand grips of normal strength bilat. Patient able to maintain sit balance when laterally poked.

Steps carefully around objects in the room. Alternative MAE equipment – Pt has attempted to use cane, walker or manual wheelchair unsuccessfully due to extreme fatigue with slight exertion described above. Assessment – Pt seems good candidate for a scooter to carry him the necessary distances in his home to use toilet/sink and kitchen facilities. Home seems amenable to this device.

Accurate and complete documentation in the physician records regarding the face-to-face examination is extremely important to ensure the patient receives an appropriate PMD.

Additional Information

If you have any questions, please visit the website of your DME MAC or contact them at their toll-free number. Their Web address and toll-free number are available at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

ATTACHMENT:
Sample Checklist for the PMD Examination

Please note, this checklist is not mandatory and does not replace the underlying medical records.

The medical record for the patient includes the following history:

______ Signs/Symptoms that limit ambulation;
______ Diagnoses that are responsible for these signs/symptoms;
______ Medications or other treatment for these signs/symptoms;
______ Progression of ambulation difficulty over time;
______ Other diagnoses that may relate to ambulatory problems;
______ How far the patient can ambulate 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, what ambulatory assistance (cane, walker, wheelchair) is currently used and why it is not sufficient;
______ What has changed in the patient’s condition that now requires the use of a power mobility device;
______ Reason for inability to use a manual wheelchair; such as assessment of upper body strength;
______ Why does the patient need a power wheelchair rather than each level of mobility assistive equipment (a cane, walker, optimally configured manual wheelchair, scooter)? What are the reasons that the patient should not or could not use a cane, walker, optimally configured manual wheelchair or power operated vehicle (scooter) in the home to satisfy their needs?; and
______ Description of the home setting, including the ability to perform activities of daily living in the home, as well as the ability to utilize the PMD in the home.

The physical examination is relevant to the patient’s mobility needs and the medical record for the patient contains:

______ Weight and Height
______ 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 a documented observation of ambulation (with use of cane or walker as appropriate)
Electronic Data Interchange (EDI)

Medicare Remit Easy Print (MREP) and PC Print User Guide Update for Implementation of Version 5010A1

**MLN Matters® Number:** MM7466  
**Related Change Request (CR) #:** 7466  
**Related CR Release Date:** July 29, 2011  
**Effective Date:** January 1, 2012  
**Related CR Transmittal #:** R926OTN  
**Implementation Date:** January 3, 2012

**Provider Types Affected**
This article is for physicians, providers, and suppliers using the Medicare Remit Easy Print (MREP) and PC Print software in relation to remittance advices they receive from Medicare contractors (carriers, Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs) and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

**What You Need to Know**
MREP and PC Print have been updated to include the latest enhancements as part of implementing version 5010A1 for Transaction 835 - Health Care Claim Payment/Advice. Specifically:
- The MREP User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1; and
- The PC Print User Guide is being updated to reflect the changes in the software related to the HIPAA 5010A1 version for ASC X12 Transaction 835.

If you use MREP or PC Print, be sure to download the updated user guide for 835 version 5010A1 when they are available.

**Background**
The Centers for Medicare and Medicaid Services (CMS) is implementing the new standard for Transaction 835 (Health Care Claim Payment/Advice) Version 5010A1 adopted under the Health Insurance Portability and Accountability Act (HIPAA). Providers/Suppliers must transition to the new version on or before January 1, 2012. CMS has made MREP and PC Print software available to providers/suppliers to enable them to view/print/download the electronic remittance advice in version 5010A1 in a human readable format.

**Additional Information**

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Populating REF Segment - Other Claim Related Adjustment - for Healthcare Claim Payment/Advice or Transaction 835 Version 5010A1

**MLN Matters® Number:** MM7484 Revised  
**Related Change Request (CR) #:** CR 748  
**Related CR Release Date:** September 2, 2011  
**Effective Date:** January 1, 2012  
**Related CR Transmittal #:** R959OTN  
**Implementation Date:** January 3, 2012

**Provider Types Affected**
This article is for physicians, other providers, and suppliers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries (RHHIs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Part B services provided to Medicare beneficiaries.

**Provider Action Needed**

**STOP – Impact to You**
The Centers for Medicare and Medicaid Services (CMS) has decided that populating the Healthcare Claim Payment/Advice or Transaction 835 version 5010A1 REF segment (Other Claim Related Adjustment) at Loop 2100 (for Part B) would provide useful information to providers and suppliers, and starting in January 2012, this segment will be populated for the Part B remittance advice.

**CAUTION – What You Need to Know**
CR7484, from which this article is taken, instructs Medicare systems, effective January 1, 2012, to populate the REF segment (Other Claim Related Adjustment) at Loop 2100 with qualifiers designated in the updated Flat File attached to CR7484. Note that CR also updates the 835 flat file by adding:
- PLB Code 90;  
- Qualifier “PQ” to be used in Loop 1000B REF – Payee Additional Information under some special situations where the National Provider Identifier (NPI) is not available; and  
- Qualifier “F1” to be used in Loop 2100 NM1 – service payable under some special situations where NPI is not available.

**GO – What You Need to Do**
You should make sure that your billing staffs are aware of this change.

**Background**
Currently the Healthcare Claim Payment/Advice or Transaction 835 REF segment (Other Claim Related Adjustment) at Loop 2100...
is not being populated for the Part B remittance advice, and the 835 Flat File identifies this with a note: “N/U by Part B.”

CMS has decided that using this segment would provide useful information to providers and suppliers. Therefore, CR7484, from which this article is taken, instructs the VIPS Medicare System (VMS) and the Multi Carrier System (MCS) to populate this segment, effective January 1, 2012, under specific situations (e.g., for cost avoid claims) using one of the qualifiers included in the updated Flat File that is an attachment to CR7484.

Specifically, VMS and MCS will use one of the following Reference Identification Qualifiers in REF01 as appropriate:

- 28: Employee Identification Number
- 6P: Group Number

(When they use this 6P qualifier, they will also populate NM1 – Corrected Priority Payer Name segment at Loop 2100 and REF02 with the Other Insured Group Number for the payer identified in NM1, and use Claim Status Code 2 in CLP02 in CLP – Claim Payment Information segment at Loop 2100);

- EA: Medical Record Identification Number
- F8: Original Reference

Note: Medicare will update Medicare Remit Easy Print (MREP) software to include this additional REF segment in the MREP Remittance Advice for version 5010A1.

Additional Information

You can find the official instruction, CR7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R959OTN.pdf on the CMS website. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

Additionally, you can learn more about CMS’s implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010A1 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0, by going to http://www.cms.gov/MMFS5010D0/01_Overview.asp#TopOfPage on the CMS website.

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

Delayed Implementation of X12N Version 5010 Paperwork Segment

CMS is delaying the implementation of the PWK (paperwork) segment associated with the X12N Version 5010 837 Professional and Institutional electronic claim transaction originally scheduled for July and October 2011. This means Medicare billers will continue to submit additional documentation which is needed for claims adjudication following the existing process established by their Medicare claims administration contractor.

CMS will give Medicare billers ample notice before implementing change requests (CR) #7041 and #7306, which change how additional documentation for claims adjudication is submitted. For additional information related to CR #7041 and #7306, please refer to the MLN Matters articles associated with these CRs:


Miscellaneous

CGS DME MAC Jurisdiction C Telephone Reopening Line

The CGS Telephone Reopening Line is available to resolve minor omissions and/or clerical errors on previously submitted claims. Generally, the telephone reopening line can correct:

- Change in date(s) of service
- Change in place of service
- Change in HCPCS code/modifiers (excluding GA, GY, GZ, and KX modifier)
- Change in number of service(s)
- Change in submitted amount(s)
- Claim lines that may have been incorrectly identified as duplicate

The following are some situations that cannot be resolved via the reopening line.

- Claims denied as unprocessable (i.e., CO-4, CO-16)
- Claims regarding procedure code E0935
- Claims involving other insurance information
- Requests to correct allocation of payment (i.e., money paid to beneficiary in error)
- Requests to extend capped rental period
- Requests to add narrative to a claim(s)
- Requests to correct a Certificate of Medical Necessity (CMN) or DME MAC Informational Form (DIF)
- Requests to correct PTAN or NPI on a claim(s)

Many situations can be resolved by resubmitting the claim(s). For assistance in resolving denied claims, visit the ANSI Denial Guide on the CGS website at http://www.cgsmedicare.com/jc/claims/pdf/JC_ANSI_denial_guide.pdf.

Before calling the reopening line, please be sure to have the following information readily available:

- NPI
- PTAN
- Last five digits of your Tax Id
- Patient’s name
- Patient’s Medicare number (HICN)
- Date(s) of service in question
- Procedure code(s) in question

You can reach the Telephone Reopening Line at: 1.866.813.7878
- 8:00 am - 10:30 a.m. and 12:00 pm - 3:30 pm Central Time.
Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update

MLN Matters® Number: MM7369
Related Change Request (CR) #: 7369
Related CR Release Date: May 6, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2213CP
Implementation Date: July 5, 2011

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), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for service provided to Medicare beneficiaries.

Provider Action Needed
Change Request (CR) 7369, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs) that are effective on July 1, 2011 for Medicare. Be sure your billing staff is 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. Additions, deactivations, and modifications to the list 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.

Both code lists are posted at http://www.wpc-edi.com/Codes on the Washington Publishing Company (WPC) website. The lists at the end of this article summarize the latest changes to these code lists, as announced in CR7369.

Additional Information
To see the official instruction (CR7369) issued to your Medicare Carrier, RHHI, DME MAC, FI and/or MAC, refer to http://www.cms.gov/Transmittals/downloads/R2213CP.pdf on the CMS website.

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 on the CMS website.

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| **Modified Codes – CARC** |
| None. |

| **Deactivated Codes – CARC** |
| None. |

| **New Codes – RARC** |
| Code | Current Narrative | Medicare Initiated |
| N542 | Missing income verification | No |
| N543 | Incomplete/invalid income verification | No |

| **Modified Codes – RARC** |
| Code | Current Narrative | Medicare Initiated |
| M37 | Not covered when the patient is under age 35. | No |
| M116 | Processed under a demonstration project or program. Project or program is ending and additional services may not be paid under this project or program. | No |
| N62 | Dates of service span multiple rate periods. Resubmit separate claims. | No |
| N356 | Not covered when performed with, or subsequent to, a non-covered service. | No |
| N383 | Not covered when deemed cosmetic. | No |
| N410 | Not covered unless the prescription changes. | No |
| N428 | Not covered when performed in this place of service. | No |
| N429 | Not covered when considered routine. | No |
| N431 | Not covered with this procedure. | No |

| **Deactivated Codes – RARC** |
| None. |

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

MLN Matters® Number: MM7420
Related Change Request (CR) #: CR 7420
Related CR Release Date: June 17, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R2241CP
Implementation Date: October 3, 2011

Provider Types Affected
Physicians, suppliers, and other providers who bill Medicare Fiscal Intermediaries (FIs), carriers, Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries
(RHHIs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

STOP – Impact to You
Effective October 1, 2011, you may have (depending on your contractor) an alternative, electronic method to submit your requests for Medicare Fee-For-Service (FFS) claim reopenings.

CAUTION – What You Need to Know
CR7420, from which this article is taken (effective October 1, 2011,) allows Medicare contractors to use a secure Internet portal/application to accept and process your requests for reopening Medicare FFS claims.

GO – What You Need to Do
You should make sure that your billing staffs are aware of this change.

Background

In response to requests from Medicare contractors, CR7420 (from which this article is taken) updates the current instructions in the “Medicare Claims Processing Manual” Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), to allow them to accept claimant initiated reopening requests via a secure Internet portal/application - effective October 1, 2011. (You can find this manual at http://www.cms.gov/manuals/downloads/clm104c34.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

Note: Medicare contractors may not require you to file a reopening via a secure Internet portal/application. Also, contractors are not required to offer this electronic capability.

Medicare will have a number of requirements for Medicare contractors utilizing a secure Internet portal/application for reopening. Specifically, to provide this access, contractors will:

- Incorporate a formal registration process that contains validation of the electronic signature on the reopening request, which will include, at a minimum, the use of restricted user identifiers (IDs) and passwords, and a method for authenticating that the party has completed the portal registration process and has been properly identified by the system as an appropriate user.
- Include, in the appeals case file, an indication and/or description of the validation methodology; should a redetermination and/or higher level of appeal be submitted following an adverse reopening decision.
- Ensure that secure Internet portal/applications developed for reopening activities adhere to the security standards in the Health Insurance and Portability and Accountability Act (HIPAA); and comply with all CMS security requirements regarding protected health information prior to implementation.
- Issue a reopening decision or refusal to reopen via a secure Internet portal/application only if the party has submitted the request for reopening through that application.
- Provide adequate education to participating parties:
  - Regarding system capabilities/limitations prior to implementation and utilization of the secure portal; and
  - Reminding them that participation/enrollment in the secure portal/application is at their discretion and that they bear the responsibility for the authenticity of the information being attested to in the request.
- Include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this will include a statement indicating that the document was, “electronically signed by” or “verified/approved by,” etc.
- Ensure that appropriate procedures are in place, via the secure Internet portal/application, to provide parties to the reopening with receipt confirmation of the reopening request, and instructions not to submit additional reopening requests for the same item/service via different venue (i.e., telephone, in writing, etc.).
- Consider decisions processed via a CMS approved secure Internet portal/application complete on the date the electronic reopening decision notice is transmitted to the party through the secure Internet portal/application.
- Ensure that there is a process in place by which a party can submit, via the secure application/portal; additional documentation/materials concurrent with the reopening request (i.e. ensure that the portal/application has the capability to accept additional documentation and/or other materials to support the reopening request.)
- Include a mechanism that tracks and marks the date/time of the notification so the submitting party is adequately informed about the timeframes required to ensure timely submission of future appeal requests for the item/service at issue, if applicable; and ensure that parties may save and print the refusal to reopen notice and the adverse revised determination/decision notice.
- Ensure that refusal to reopen and adverse revised determination notices transmitted via a secure Internet portal/application comply with the timeliness and content requirements as outlined in the “Medicare Claims Processing Manual,” Chapter 34.
- Provide hard copy adverse revised determination/decision notices to parties to the reopening who do not have access to the secure Internet portal/application; and ensure that these notices are mailed and/or otherwise transmitted on the same day the notice is transmitted via the secure portal/application.)
- Include the adverse revised determination/decision notice and any other related materials in the appeals case file if a valid appeal on the item/service is later requested.

Contractors will not issue a refusal to reopen notice if they begin processing a valid and timely request for redetermination as a reopening (clerical error or otherwise) and later determine that a reopening cannot be performed, or the determination cannot be changed. Rather, they will process the request as a valid/timey redetermination (as originally requested by the party) in accordance with the “Medicare Claims Processing Manual,” Edition 17 · Fall 2011

Additionally Information
You can find the official instruction, CR7420, issued to your FI or A/B MAC by visiting http://www.cms.gov/transmittals/downloads/R2241CP.pdf on the Centers for Medicare & Medicaid (CMS) website. You will find the updated "Medicare Claims Processing Manual," Chapter 34 (Reopening and Revision of Claim Determinations and Decisions), Sections 34.10 (Reopenings and Revisions of Claims Determinations and Decisions-General), 34.10.1 (Authority to Conduct a Reopening), 34.10.6.4 (Timeframes When a Party Requests an Adjudicator Reopen Their Decisions), 34.10.7 (Timeframes to Complete a Reopening Requested by a Party), 34.10.8 (Notice of a Revised Determination or Decision), and 34.10.13 (System and Processing Requirements for Use of Secure Internet Portal/Application to Support Reopening Activities) as an attachment to that CR. If you have any questions, please contact your FI, carrier, A/B MAC, RHHI, or DME MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the Centers for Medicare & Medicaid Services (CMS) website.

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

MLN Matters® Number: MM7436
Related Change Request (CR) #: 7436
Related CR Release Date: July 29, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R192FM
Implementation Date: January 3, 2012

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

Provider Action Needed
STOP – Impact to You
This article is based on Change Request (CR) 7436 which announces that Medicare’s Recovery Auditors will no longer issue demand letters to you as of January 3, 2012.

CAUTION – What You Need to Know
Recovery Auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the Recovery Auditor’s review, and issue an automated demand letter to you.

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

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

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

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

To see the official instruction (CR7436) issued to your Medicare contractor, see http://www.cms.gov/Transmittals/downloads/R192FM.pdf on the CMS website.

Quarterly Update to the End-Stage Renal Disease Prospective Payment System

MLN Matters® Number: MM7476
Related Change Request (CR) #: 7476
Related CR Release Date: July 15, 2011
Effective dates: 10/01/2011 ICD-9 Updates, 01/01/2011 DME Updates
Related CR Transmittal #: R2255CP
Implementation Date: October 3, 2011

Provider Types Affected
Physicians, providers, and suppliers, including End-Stage Renal Disease (ESRD) facilities and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, submitting claims to Fiscal Intermediaries (FIs), DME Medicare Administrative Contractors (DME MACs), or A/B MACs for ESRD supplies and services provided to Medicare beneficiaries are affected by this article.

Provider Action Needed
This article, based on Change Request (CR) 7476, advises you about the following corrections to Attachment 4 and Attachment 5 provided in CR7064:
• Removes equipment and supply codes from Attachment 4 that are not separately payable to DMEPOS suppliers, and
• Adds these removed codes to Attachment 5.

You are also advised of the update to Attachment 8 provided with CR7064, which is the list of ICD-9-CM codes eligible for the ESRD Prospective Payment System (PPS) co-morbidity payment adjustment. The list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective January 1, 2011 and the list of ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 is available at http://www.cms.gov/ESRDPayment/40_Comorbidity_Conditions.asp#TopOfPage on the Centers for Medicare & Medicaid Services (CMS) website.

The revised attachments 4 and 5 are attached to CR7476 at http://www.cms.gov/Transmittals/downloads/R22SSCP.pdf on the CMS website. Items and services that are subject to the ESRD PPS consolidated billing requirements can be found at http://www.cms.gov/ESRDPayment/50_Consolidated_Billing.asp#TopOfPage on the CMS website.

Please be sure to inform your staffs of these changes.

Background

MM7064, entitled “End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Consolidated Billing for Limited Part B Services,” advised you about the implementation of a new bundled payment system for renal dialysis items and services provided on and after January 1, 2011. You may review this article by going to http://www.cms.gov/MLNMattersArticles/downloads/MM7064.pdf on the CMS website.

The ESRD PPS provides payment adjustments for six categories (three acute and three chronic) of co-morbid conditions. When applicable, ESRD facilities can report specific ICD-9-CM diagnosis codes on ESRD facility claims to be eligible for a co-morbidity payment adjustment. The ICD-9-CM codes are updated annually and are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems and are effective each October 1. CR7476 provides updates to attachment 8 of CR7064, which includes the ICD-9-CM codes eligible for the ESRD PPS co-morbidity payment adjustment in accordance with the annual ICD-9-CM update, which is effective October 1, 2011.

Changes to the ICD-9-CM codes that are eligible for a co-morbidity payment adjustment effective October 1, 2011 include:

1. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.41 – Sickle-cell thalassemia without crisis has been revised to include microdyserythrocytosis.

2. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, the 5 new ICD-9 codes added are as follows:
   - 282.43 Alpha thalassemia
     - Alpha thalassemia major
     - Hemoglobin H Constant Spring
     - Hemoglobin H disease

   - Hydrops fetalis due to alpha thalassemia
   - Severe alpha thalassemia
   - Triple gene defect alpha thalassemia

   Excludes: Alpha thalassemia trait or minor (282.46); hydrops fetalis due to isoimmunization (773.3); hydrops fetalis not due to immune hemolysis (778.0)

   ▪ 282.44 Beta thalassemia
   - Beta thalassemia major
   - Cooley’s anemia
   - Homozygous beta thalassemia
   - Severe beta thalassemia
   - Thalassemia intermedia
   - Thalassemia major

   Excludes: Beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); hemoglobin E beta thalassemia (282.47); sickle-cell beta thalassemia (282.41, 282.42)

   ▪ 282.45 Delta-beta thalassemia
   - Homozygous delta-beta thalassemia
   - Excludes: delta-beta thalassemia trait (282.46)

   ▪ 282.46 Thalassemia minor
   - Alpha thalassemia minor
   - Alpha thalassemia trait
   - Alpha thalassemia silent carrier
   - Beta thalassemia minor
   - Beta thalassemia trait
   - Delta-beta thalassemia trait
   - Thalassemia trait NOS

   Excludes: Alpha thalassemia (282.43); beta thalassemia (282.44); delta beta thalassemia (282.45); hemoglobin E-beta thalassemia (282.47); sickle-cell trait (282.5)

   ▪ 282.47 Hemoglobin E-beta thalassemia

   Excludes: Beta thalassemia (282.44); beta thalassemia minor (282.46); beta thalassemia trait (282.46); delta-beta thalassemia (282.45); delta-beta thalassemia trait (282.46); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle-cell beta thalassemia (282.41, 282.42)

3. In the chronic comorbid conditions under the hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to no longer include Cooley’s anemia, Hb-Bart’s disease, Microdyserythrocytosis, Thalassemia (alpha) (beta) (intermedia) (major) (minima) (minor) (mixed) (trait), and Thalassemia NOS.

4. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to include Dominant thalassemia, Hemoglobin C thalassemia, Mixed thalassemia, and continues to include Thalassemia with other hemoglobinopathy.

5. In the chronic comorbid conditions under hereditary hemolytic and sickle cell anemia category, ICD-9 code 282.49 – Other thalassemia has been revised to exclude hemoglobin C disease (282.7); hemoglobin E disease (282.7); other hemoglobinopathies (282.7); sickle cell anemias (282.60-282.69); and sickle-cell beta thalassemia (282.41-282.42)
Attachment 4 of CR7064, DME ESRD Supply Healthcare Common Procedure Coding System (HCPCS) for ESRD PPS Consolidated Billing Edits, included the list of equipment and supplies that are ESRD-related but can be used in other provider settings for reasons other than for the treatment of ESRD. Attachment 5 of CR7064, DME ESRD Supply HCPCS Not Payable to DME Suppliers, included the list of the DME ESRD supply codes that are no longer separately payable to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers. To allow DMEPOS suppliers to get paid for furnishing these services under other circumstances covered by Medicare, CR7064 provided instructions stating that DMEPOS suppliers may bill the items listed on Attachment 4 with the AY modifier to indicate that the item is used for reasons other than for the treatment of ESRD. Currently, there are equipment and supplies listed on Attachment 4 that are not used in other provider settings that are ESRD-related but can be used in other provider settings for reasons other than for the treatment of ESRD. Therefore, these items would not be covered by Medicare because there is no other benefit category that can provide coverage. CR7476 rescinds and replaces Attachments 4 and 5 of CR7064 as follows: Removes equipment and supply codes from Attachment 4 that are either not separately payable or not payable by Medicare and add these codes to Attachment 5. Surgical dressing code A6204 will also be included in Attachment 5.

Additional Information
The official instruction, CR7476, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2255CP.pdf on the CMS website.

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

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

MLN Matters® Number: MM7499  
Related Change Request (CR) #: CR 7499  
Related CR Release Date: August 5, 2011  
Effective Date: January 1, 2012  
Related CR Transmittal #: R940OTN  
Implementation Date: April 2, 2012

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

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

Background
The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA as a response to provider request per CR6870 and CR7068. The MLN Matters article corresponding to CR6870 can be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf and CR7068 can be reviewed at http://www.cms.gov/transmittals/downloads/R812OTN.pdf on the CMS website.

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

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

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

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

Additional Information
The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R940OTN.pdf on the CMS website.

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

July 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters® Number: MM7357
Related Change Request (CR) #: 7357
Related CR Release Date: March 25, 2011
Effective Date: July 1, 2011
Related CR Transmittal #: R2182CP
Implementation Date: July 5, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7357, which instructs Medicare contractors to download and implement the July 2011 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2011, January 2011, October 2010, and July 2010 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 July 1, 2011, with dates of service July 1, 2011, through September 30, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

Background
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective for Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2010 ASP and ASP NOC files</td>
<td>July 1, 2010, through September 30, 2010</td>
</tr>
<tr>
<td>April 2011 ASP and ASP NOC files</td>
<td>April 1, 2011, through June 30, 2011</td>
</tr>
<tr>
<td>January 2011 ASP and ASP NOC files</td>
<td>January 1, 2011, through March 31, 2011</td>
</tr>
<tr>
<td>October 2010 ASP and ASP NOC files</td>
<td>October 1, 2010, through December 31, 2010</td>
</tr>
</tbody>
</table>

Additional Information
If you have questions, please contact your Medicare MAC, carrier, or FI at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website. The official instruction (CR 7357) issued to your Medicare MAC, carrier, and FI may be found at http://www.cms.gov/transmittals/downloads/R2182CP.pdf on the CMS website.

July Quarterly Update for 2011 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters® Number: MM7416
Related Change Request (CR) #: 7416
Related CR Release Date: June 3, 2011
Effective Date: January 1, 2011, for fee schedule amounts for codes effective on that date; otherwise July 1, 2011
Related CR Transmittal #: R2236CP
Implementation Date: July 5, 2011

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 Change Request (CR) 7416 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) 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 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 on CMS website.

Key Points of CR7416
Fees Added
The July Quarterly Update for the 2011 DMEPOS Fee Schedule Part B files established fee schedule amounts for Healthcare
Common Procedure Coding System (HCPCS) codes A7020, E1831, and L5961, effective for claims with dates of service on or after January 1, 2011.

Note: Claims for codes A7020, E1831, and L5961 with dates of service on or after January 1, 2011, that were previously processed may be adjusted to reflect the newly established fees if you bring those claims to your contractor’s attention.

Temporary “K” Codes
The following new K codes will be added to contractor’s system effective for dates of service July 1, 2011:

- K0743 – SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
- K0744 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
- K0745 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
- K0746 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES

Note: The addition of these codes does not imply any health insurance coverage. Medicare contractors will follow their normal processes in determining whether sufficient evidence exists to determine if these items are reasonable and necessary and covered under Medicare.

Code Updates
- HCPCS code E0571 (AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER) will be made invalid for Medicare claims, effective July 1, 2011.
- The payment category for HCPCS code A4619 (FACE TENT) is being revised as part of this quarterly update to move this nebulizer accessory from the DME payment category for oxygen and oxygen equipment to the DME payment category for inexpensive or other routinely purchased items, effective July 1, 2011. The DMEPOS fee schedule file will be updated to reflect this change.

Payment for Oxygen Contents
Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. After the 36-month rental payment period (cap), separate payment may be made for oxygen contents for the remainder of the equipment’s reasonable useful lifetime. However, separate payment for oxygen contents ends when replacement stationary oxygen equipment is furnished causing a new 36-month rental payment period to begin. Also, separate oxygen contents payment is allowable for beneficiary-owned stationary or portable gaseous or liquid oxygen equipment. Beginning with dates of service on or after the end date of service for the month representing the 36th payment for the stationary oxygen equipment (codes E0424, E0439, E1390 or E1391), a supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

<table>
<thead>
<tr>
<th>Oxygen Equipment Furnished in Month 36</th>
<th>Monthly Contents Payment after the Stationary Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen Concentrator (E1390, E1391, or E1392)</td>
<td>None</td>
</tr>
<tr>
<td>Portable Gaseous or Liquid Transfiling Equipment (K0738 or E0433)</td>
<td>None</td>
</tr>
<tr>
<td>E0424 Stationary Gaseous System</td>
<td>E0441 Stationary Gaseous Contents</td>
</tr>
<tr>
<td>E0439 Stationary Liquid System</td>
<td>E0442 Stationary Liquid Contents</td>
</tr>
<tr>
<td>E0431 Portable Gaseous System</td>
<td>E0443 Portable Gaseous Contents</td>
</tr>
<tr>
<td>E0434 Portable Liquid System</td>
<td>E0444 Portable Liquid Contents</td>
</tr>
</tbody>
</table>

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0433 or E0444) may begin following the stationary oxygen equipment payment cap AND before the end of the portable equipment cap (E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable equipment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment’s reasonable useful lifetime or is lost, stolen, or irreparably damaged). Under no circumstances would monthly payment be made for both stationary oxygen equipment and either stationary or portable oxygen contents.

Proof-of-Delivery Requirements for Oxygen Contents
Following the oxygen equipment payment cap, oxygen content billing should be made on the anniversary date of the oxygen equipment billing.

At all times, the supplier is responsible for ensuring that the beneficiary has a sufficient quantity of oxygen contents and is never in danger of running out of contents. A maximum of 3 months of oxygen contents can be delivered to the beneficiary at one time and billed on a monthly basis. In these situations, the delivery date of the oxygen contents does not have to equal
the date of service (anniversary date) on the claim, but in order to bill for contents for a specific month (i.e. the second or third month in the three month period), the supplier must have delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen, which may be less than monthly within the three month period. If the supplier delivers more than one month of oxygen contents at a time (2 to 3), the supplier is not entitled to payment for additional months 2 and 3 if medical need ceases before the date when the supplier would be entitled to bill for those months.

**Payment for Replacement of Equipment After Repairs**
Under the regulations at 42 CFR 414.210(e)(4), a supplier that transfers title to a capped rental DME item to the beneficiary is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if it is determined that the item will not last until the end of its 5 year reasonable useful lifetime. In making this determination, Medicare contractors may consider whether the accumulated costs of repairing the item exceed 60 percent of the purchase fee schedule amount for the item.

Furthermore, 42 CFR 424.57(14) requires a DMEPOS supplier to maintain or replace a Medicare-covered item it has rented to beneficiaries to its intended status after being repaired. Recent cases have arisen whereupon after multiple repairs, the item continues to malfunction. CR7416 instructs your Medicare contractor to be aware of and educate suppliers of these regulatory requirements to replace DME items for which repairs have not restored the item. Also, after receipt of multiple repair claims, contractors will investigate suspicious claims for replacement equipment billed with its HCPCS code and the RA modifier.

**Additional Information**
If you have any questions, please contact your Medicare Carrier, DME MAC, FI, RHHI, or A/B MAC 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.

The official instruction associated with this CR7416 issued to your Medicare Carrier, FI, DME MAC, RHHI or A/B MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R2236CP.pdf](http://www.cms.gov/Transmittals/downloads/R2236CP.pdf) on the CMS website.

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**October 2011 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files**

**MLN Matters® Number:** MM7488  
**Related Change Request (CR) #:** 7488  
**Related CR Release Date:** July 29, 2011  
**Effective Date:** October 1, 2011  
**Related CR Transmittal #:** R2264CP  
**Implementation Date:** October 3, 2011

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

**Provider Action Needed**
This article is based on Change Request (CR) 7488, which instructs Medicare contractors to download and implement the October 2011 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised July 2011, April 2011, January 2011, and October 2010 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 1, 2011, with dates of service October 1, 2011, through December 31, 2011. Contractors will not search and adjust claims that have already been processed unless brought to their attention. Please ensure that your staffs are aware of this quarterly update.

**Background**
The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS supplies Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

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

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<tr>
<th>Files</th>
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<tbody>
<tr>
<td>October 2011 ASP and ASP NOC</td>
<td>October 1, 2011, through December 31, 2011</td>
</tr>
<tr>
<td>July 2011 ASP and ASP NOC</td>
<td>July 1, 2011, through September 30, 2011</td>
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<tr>
<td>April 2011 ASP and ASP NOC files</td>
<td>April 1, 2011, through June 30, 2011</td>
</tr>
<tr>
<td>January 2011 ASP and ASP NOC files</td>
<td>January 1, 2011, through March 31, 2011</td>
</tr>
<tr>
<td>October 2010 ASP and ASP NOC files</td>
<td>October 1, 2010, through December 31, 2010</td>
</tr>
</tbody>
</table>
HCPCS Updates


**MLN Matters® Number:** MM7303  
**Related Change Request (CR) #:** CR 7303  
**Related CR Release Date:** May 24, 2011  
**Effective Date:** July 1, 2011  
**Related CR Transmittal #:** R2227CP  
**Implementation Date:** July 5, 2011

**Provider Types Affected**

This article is for physicians, other providers, and suppliers who will Medicare contractors (carriers, Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

**What You Need to Know**

CR7303 announces the quarterly updating of specific Health Care Procedure Code System (HCPCS) codes, effective for claims with dates of service on or after July 1, 2011. You should make sure that your billing staffs are aware of these HCPCS code changes.

**Non-Payable Code**

Effective for claims with dates of service on or after July 1, 2011, Medicare will not pay for the following HCPCS code:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7184</td>
<td>Wilate injection</td>
<td>INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 100 I.U. VWF-RCO</td>
</tr>
</tbody>
</table>

**Payable Codes**

Contractors will accept the codes in the following table as payable HCPCS codes for dates of service on or after July 1, 2011, using Type of Service (TOS) 1, 9, and Medicare Physician Fee Schedule Database (MPFSDB) Status Indicator “E” (Excluded from Physician Fee Schedule by Regulation):

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2041</td>
<td>Wilate Injection</td>
<td>INJECTION, VON WILLEBRAND FACTOR COMPLEX (HUMAN), WILATE, 1 I.U. VWF-RCO</td>
</tr>
<tr>
<td>Q2042</td>
<td>Hydroxyprogesterone caproate</td>
<td>INJECTION, HYDROXYPROGESTERONE CAPROATE, 1 MG</td>
</tr>
<tr>
<td>Q2043</td>
<td>Sipuleucel-T auto CD54+</td>
<td>SIPULEUCELT, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION</td>
</tr>
<tr>
<td>Q2044</td>
<td>Belimumab injection</td>
<td>INJECTION, BELIMUMAB, 10 MG</td>
</tr>
</tbody>
</table>

**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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**New K Codes for Suction Pumps and Wound Dressings**

**MLN Matters® Number:** MM7411  
**Related Change Request (CR) #:** CR 7411  
**Related CR Release Date:** April 29, 2011  
**Effective Date:** July 1, 2011  
**Related CR Transmittal #:** R2206CP  
**Implementation Date:** July 5, 2011

**Provider Types Affected**

Providers and suppliers who will Medicare Administrative Contractors (A/B MACs) or Durable Medical Equipment contractors (DME MACs) for providing suction pumps and accompanying surgical dressings to Medicare beneficiaries.

**Provider Action Needed**

Effective July 1, 2011, Medicare will allow four new K codes for billing suction pumps and accompanying surgical dressings. Ensure that your billing staffs are aware of these new K codes, which are effective for dates of service on or after July 1, 2011. The codes and their descriptors are as follows:

- **K0743** - SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS;  
- **K0744** - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS;  
- **K0745** - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL; PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES; and  
- **K0746** - ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES.
Note: The coverage type for these codes is “C,” and their coverage is subject to your contractor’s discretion. Further, the addition of these codes does not imply their coverage by Medicare.

Additional Information
You can find the official instruction, CR7411, issued to your A/B MAC or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2206CP.pdf on the Centers for Medicare & Medicaid (CMS) website.

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

Competitive Bidding

Durable Medical Equipment National Competitive Bidding: Correction to Permit Payment for Certain Grandfathered Accessories and Supplies

MLN Matters® Number: MM7389 Revised
Related Change Request (CR) #: 7389
Related CR Release Date: July 14, 2011
Effective Date: October 1, 2011
Related CR Transmittal #: R912OTN
Implementation Date: October 3, 2011

Note: This article was revised on July 18, 2011, to reflect the changes made to CR7389. The changes clarify that patients are in the inexpensive or routinely purchased payment category and the rental period caps for the two payment categories (capped rental and inexpensive or routinely purchased) are calculated differently. The CR release date, transmittal number and Web link to access the CR have also changed. All other information remains the same.

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for certain grandfathered accessories and supplies furnished to Medicare beneficiaries after the start of a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP).

Provider Action Needed
STOP – Impact to You
This article is based on CR7389 which informs Medicare suppliers and DME MACs that Medicare payment is permissible to a non-contract, grandfathered supplier for furnishing certain purchased, covered accessories or supplies furnished for use with capped rental equipment.

CAUTION – What You Need to Know
There are limitations on the duration of this permission as well as constraints on the applicable Healthcare Common Procedure Coding System (HCPCS) codes. The KY modifier should not be annotated on claims for these HCPCS codes after September 30, 2011.

GO – What You Need to Do
See the Background and Key Points Sections of this article for clarification and details regarding these changes.

Background
Under the Medicare DMEPOS CBP a beneficiary who obtains competitive bidding items in a designated Competitive Bidding Area (CBA) must obtain these items from a contract supplier, unless an exception applies such as the ones presented below exist.

Exception 1
A beneficiary may continue to obtain certain rental items from a non-contract supplier if the beneficiary was receiving such rental items from the non-contract supplier when the CBP took effect in the CBA. Such a non-contract supplier would be considered a “grandfathered supplier” with respect to such rented item and such beneficiary for the remainder of the particular item’s existing rental period.

Exception 2 (related to exception above)
A beneficiary, who continues to obtain a rented, grandfathered competitive bidding item from a non-contract grandfathered supplier, may also obtain certain purchased, covered accessories or supplies furnished for use with such rented “grandfathered” equipment from the same non-contract grandfathered supplier until the equipment’s payment cap is reached. The purchased, covered accessories or supplies used with rented, grandfathered equipment within the same product category that are subject to this exception are identified by applicable HCPCS codes, as follows:

- Hospital Beds and Related Accessories – E0271, E0272, E0280, and E0310; and
- Walkers and Related Accessories – E0154, E0156, E0157, and E0158

Previously, non-contract grandfathered suppliers submitting claims for purchased, covered accessories or supplies under this exception were told to use the KY modifier on claims for such items with dates of service on or after January 1, 2011.

Key Points in CR7389
Effective October 1, 2011, the KY modifier is not required on these claims. Any claims submitted after September 30, 2011 with the KY modifier will be denied.

Medicare payment may be made to a non-contract, grandfathered supplier for furnishing certain purchased, covered accessories or supplies furnished for use with rented,
grandfathered equipment, provided the non-contract supplier is also furnishing the rented equipment on a grandfathered basis. The purchased, covered accessories or supplies that are subject to this policy, identified by applicable HCPCS codes, are previously listed.

For rented, grandfathered equipment in the capped rental payment class (e.g. CPAP device), after the rental payment cap for the grandfathered equipment is reached:

- The beneficiary must obtain covered accessories and supplies (e.g. CPAP masks) only from a contract supplier;
- The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies;
- Medicare payment will no longer be made to a non-contract, grandfathered supplier for furnishing such purchased accessories or supplies; and

For rented, grandfathered equipment in the inexpensive or routinely purchased payment class (e.g. folding walker) reach the purchase fee schedule amount for the grandfathered equipment:

- The beneficiary must obtain covered accessories (e.g. seat attachment) and supplies only from a contract supplier; and
- The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies once the capped rental payment cap is reached.

These claims will be denied, using the following messages:

- B20 – Procedure /service was partially or fully furnished by another provider;
- N211 – You may not appeal this decision; and
- M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.

Medicare contractors will also assign group code CO (Contractual Obligation).

Note: In all cases, payment for covered accessories and supplies used in conjunction with a grandfathered item is based on the single payment amount calculated for the item for the CBA in which the beneficiary maintains a permanent residence.

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.

The official instruction associated with this CR7389, issued to your Medicare MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R912OTN.pdf](http://www.cms.gov/Transmittals/downloads/R912OTN.pdf) on the CMS website.

To review a complete listing of links to DME related information you may go to [https://www.cms.gov/center/dme.asp](https://www.cms.gov/center/dme.asp) on the CMS website.
on January 1, 2011. CR 7401 provides additional instructions on changes under the DMEPOS Competitive Bidding Program. This regulation is available at http://www.cms.hhs.gov/DMEPOSCompetitiveBid on the CMS website.

Key Points of CR7401

There are seven additions to section 50 of Chapter 36 of the “Medicare Claims Processing Manual”; one is an update and the other six are new additions:

- Section 50.3 is updated to include new HCPCS modifiers developed to facilitate implementation of various policies that apply to certain competitive bidding items. The KG, KK, KU, KW, and KY modifiers are pricing modifiers that suppliers must use to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories.
  - For example, HCPCS code E0981 (Wheelchair Accessory, Seat Upholstery, Replacement Only, Each) is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category must submit E0981 claims using the KG modifier, whereas contract suppliers for the complex rehabilitative power wheelchair product category must use the KK modifier. All suppliers, including grandfathered suppliers, shall submit claims for competitive bid items using the aforementioned competitive bidding modifiers.
  - The KG and KK modifiers are used in Round I of the competitive bidding program and the KU and KW modifiers are reserved for future program use.

The six sections added to Chapter 36: 50.10 through 50.15 as follows:

- 50.10 - Claims Submitted for Hospitals Who Furnish Competitively Bid Items;
  - Under DMEPOS Competitive Bidding, hospitals may furnish certain types of competitively bid DME to their patients on the date of discharge without submitting a bid and being awarded a contract. The DME items that a hospital may furnish as part of the exception are limited to crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. Payment for items furnished under this exception will be made based on the single payment amount for the item in the beneficiary’s CBA. In these situations, Medicare payment for labor will be based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment that are submitted with the RB modifier will be based on the single payment amount for the item, if the part and equipment being repaired are included in the same competitive bidding product category in the CBA.
  - Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.
  - The replacement of an entire item, as opposed to the replacement of a part for repair purposes, which is subject to the DMEPOS Competitive Bidding Program, must be furnished by a contract supplier. Medicare payment for the replacement item would be based on the single payment amount for the item in the beneficiary’s CBA. Refer to the “Medicare Claims Processing Manual”, Chapter 20, 10-2 at http://www.cms.gov/manuals/downloads/clm104c20.pdf for instruction for submitting claims for repairs and replacements.

- 50.11 - Claims for Repairs and Replacements;
  - Under the DMEPOS Competitive Bidding Program, any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA. In these situations, Medicare payment for labor will be based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment that are submitted with the RB modifier will be based on the single payment amount for the item, if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.

- 50.12 – Claims for Repairs and Replacements;
  - Under the DMEPOS Competitive Bidding Program, any DMEPOS supplier, provided they have a valid Medicare billing number, can furnish and bill for services (labor and parts) associated with the repair of DME or enteral nutrition equipment owned by beneficiaries who reside in a CBA. In these situations, Medicare payment for labor will be based on the standard payment rules. Medicare payment for replacement parts associated with repairing competitively bid DME or enteral nutrition equipment that are submitted with the RB modifier will be based on the single payment amount for the item, if the part and equipment being repaired are included in the same competitive bidding product category in the CBA. Otherwise, Medicare payment for replacement parts associated with repairing equipment owned by the beneficiary will be made based on the standard payment rules.

- 50.13 - Billing for Oxygen Contents to Suppliers After the 36th Month Rental Cap;
  - The Medicare law requires that the supplier that furnishes liquid or gaseous oxygen equipment (stationary or portable) for the 36th continuous month must continue to furnish the oxygen contents necessary for the effective use of the liquid or gaseous equipment during any period after the payment cap and of medical need for the remainder of the reasonable useful lifetime established for the equipment. This requirement continues to apply under the Medicare DMEPOS Competitive Bidding Program, regardless of the role of the supplier (i.e., contract supplier, grandfathered supplier, or non-contract supplier) and the location of the beneficiary (i.e. residing within or outside a CBA).
  - Should a beneficiary travel or temporarily relocate to a CBA, the oxygen supplier that received the payment for
the 36th continuous month must make arrangements for furnishing oxygen contents with a contract supplier in the CBA in the event that the supplier that received the 36th month payment elects to make arrangements for a temporary oxygen contents billing supplier.

- The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. If the beneficiary resides in a CBA, payment for the oxygen contents will be based on the single payment amount for that CBA. If the beneficiary resides outside of a CBA and travels to a CBA, payment for the oxygen contents will be based on the fee-schedule amount for the area where the beneficiary maintains a permanent residence.

50.14 - Purchased Accessories & Supplies for Use With Grandfathered Equipment; and

- Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011 for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. The following HCPCS codes are the codes for which use of the KY modifier is authorized:

  ✓ Hospital Beds and Related Accessories – E0271, E0272, E0280, E0310; and
  ✓ Walkers and Related Accessories – E0154, E0156, E0157 and E0158.

- Grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. Non-contract grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. In addition, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.

- After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

50.15 - Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge.

- Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

- To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 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. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.

- Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier to claims submitted for these items.

- The J4 modifier should not be used by contract suppliers.

**Additional Information**

If you have any questions, please contact your Medicare Carrier, FI, RHHI, A/B MAC, or DME MAC 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. The official instruction associated with this CR7401, issued to your Medicare MAC regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R2231CP.pdf](http://www.cms.gov/Transmittals/downloads/R2231CP.pdf) on the CMS website.

Additional information regarding this program, including tip sheets for specific Medicare provider audiences, can be found at [http://www.cms.hhs.gov/DMEPOSCompetitiveBid/](http://www.cms.hhs.gov/DMEPOSCompetitiveBid/) on the CMS website. Click on the “Provider Educational Products and Resources” tab and scroll down to the “Downloads” section.

**October 2011 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program**

- **MLN Matters® Number:** MM7425
- **Related Change Request (CR) #:** 7425
- **Related CR Release Date:** May 20, 2011
- **Effective Date:** October 1, 2011
- **Related CR Transmittal #:** R2225CP
- **Implementation Date:** October 3, 2011

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 7425 which provides the DMEPOS October 2011 quarterly update. This update implements necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, single payment
amount and supplier files, effective October 1, 2011. Be sure your billing staffs are aware of these changes.

Background
The Round One Rebid Competitive Bidding Program was implemented on January 1, 2011, in Competitive Bidding Areas (CBAs) defined by ZIP codes within nine of the largest Metropolitan Statistical Areas (MSAs). The CBAs in the Round One Rebid include: Charlotte-Gastonia-Concord, NC-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Pompano Beach, FL; Orlando-Kissimmee, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA.

A list of the HCPCS codes that are included in each of the Round One Rebid product categories can be accessed by visiting the Competitive Bidding Implementation Contractor’s (CBIC) website at http://page2rss.com/page?url=www.dmecompetitivebid.com/palmetto/CBIC.nsf/DocsCat/Home on the Internet.

Key Points of CR7425
Competitive Bidding ZIP Codes
For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA number. The competitive bidding CBA numbers and associated names are as follows:

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

Public Use Files
The competitive bidding zip codes and single payment amounts per product category and CBA are available on the CBIC website for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The CBIC website can be accessed at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home or by visiting http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp

Single Payment Amount on the Centers for Medicare & Medicaid Services (CMS) website. These files can be used to identify when a specific item furnished to a beneficiary is subject to the DMEPOS competitive bidding program.

The single payment amount is the Medicare allowed payment amount, instead of the previous fee schedule amount, for competitive bidding items for beneficiaries who reside in CBAs. Medicare will pay contract suppliers 80 percent of the single payment amount for each competitively bid item. The beneficiaries will be responsible for the remaining 20 percent of the single payment amount. Payment for all claims is on an assignment-related basis. In no case can a beneficiary be charged more than the 20 percent coinsurance payment for medically necessary items.

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months.

The changes to the power wheelchair payment rules made by Section 3136 of the Affordable Care Act do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011, or for power wheelchairs in which the first rental month occurred before January 1, 2011. Therefore, under the Round One Rebid Competitive Bidding Program, contract and grandfathered suppliers furnishing rented power wheelchairs will continue to be paid under the capped rental payment methodology using 10 percent of the single payment amount for the first three months and 75 percent of the single payment amounts paid in the first three rental months for months 4 through 13. Similarly, the elimination of the lump sum purchase option for standard power wheelchairs, as required by Section 3136 of the Affordable Care Act, does not apply to standard power wheelchairs furnished by contract suppliers under the Round One Rebid Program. Payment for standard power wheelchairs will continue to be made to Round One Rebid contract suppliers on either a lump sum purchase or rental basis.

For inexpensive and/or routinely purchased DME items, the recorded single payment amount for rental is 10 percent of the purchase single payment amount. For all equipment furnished on a purchase basis, the recorded single payment amount for purchased used equipment is 75 percent of the purchase single payment amount.
Also included in the CBA pricing file and the single payment amount file is the maintenance and servicing single payment amount for rented enteral nutrition infusion pumps described by HCPCS codes B9000 and B9002, made in accordance with the “Medicare Claims Processing Manual,” Section 40.3, Chapter 20, which may be found at http://www.cms.gov/manuals/downloads/clm104c20.pdf on the CMS website. The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

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

The official instruction associated with this CR7425 issued to your Medicare DME MAC or RHHI regarding this change may be viewed at http://www.cms.gov/transmittals/downloads/R2225CP.pdf on the CMS website.

For a more expansive coverage of the January 2011 DMEPOS competitive bidding program and HCPCS codes see MLN Matters® article MM7181 at http://www.cms.gov/MLNProducts/downloads/MM7181.pdf on the CMS website.

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

MLN Matters® Number: MM7498
Related Change Request (CR) #: 7498
Related CR Release Date: August 12, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R9480TN
Implementation Date: January 3, 2012

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

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

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

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

Key Points
- Claims will be paid when submitted by a National Competitive Bidding (NCB) contract or non-contract supplier for the maintenance and servicing of enteral nutrition pumps, provided the supplier furnished the pump to the beneficiary in the 15th month of continuous rental and provided that, in the case of a non-contractor supplier, the 15th month of rental occurred before the start of the competitive bidding round (January 1, 2011).
- Claims will be denied if submitted by non-contract suppliers for maintenance and servicing if the supplier did not provide the item in the 15th month of the rental period or if the 15th month occurred on or after the start of the competitive bidding round.
- For denied claims, DME MACs will supply the following messages on the remittance advice:
  - 96 – Non-covered charge(s).
  - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
  - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other demonstration project. For more information regarding this project, contact your local contractor.
  - N211 – Alert: You may not appeal this decision.
  - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
  - Group Code CO.
- Suppliers will be paid the Medicare payment amount for maintenance and servicing of enteral nutrition equipment equal to a percentage of the fee schedule for the purchase or rental of the enteral equipment, as applicable.
- For maintenance and servicing claims submitted by a non-contract supplier, Medicare Contractors will pay 50 percent of the fee schedule amount for a single month’s rental of enteral nutrition equipment.
- For maintenance and servicing claims submitted by contract suppliers, Medicare Contractors will pay 5 percent of the
single payment amount for the purchase of enteral nutrition equipment.
- Payments are allowed for maintenance and servicing of enteral nutrition equipment furnished by contract or non-contract suppliers until the earlier of either a determination is made by the beneficiary’s physician that the equipment is no longer medically necessary or the end of the Reasonable Useful Lifetime (RUL) of the equipment.
- DMEPOS Competitive Bidding Program claims submitted by non-contract suppliers for maintenance and servicing of enteral nutrition equipment with dates of service between January 1, 2011, and December 31, 2011, and which were previously denied, will be reprocessed by your Medicare contractor if the supplier submitting the adjustment received payment for the 15th month of equipment rental prior to the start of the competitive bidding round.

Additional Information
The official instruction, CR7498 issued to your DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R948OTN.pdf on the CMS website. If you have any questions, please contact your DME MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

Claims Modifiers for Use in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program
MLN Matters Number: SE1035 Revised
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Note: This article was revised on July 25, 2011 to provide important new information regarding the KY modifier on page 4. All other information remains unchanged.

Provider Types Affected
All Medicare Fee-For-Service (FFS) providers and suppliers who provide Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to Medicare beneficiaries with Original Medicare who reside in a Competitive Bidding Area (CBA), including: contract and non-contract suppliers; physicians and other treating practitioners providing walkers to their own patients; hospitals providing walkers to their own patients; and Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) that provide enteral nutrition to residents with a permanent residence in a CBA.

Background
Under the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, beneficiaries with Original Medicare who obtain competitive bidding items in designated CBAs are required to obtain these items from a contract supplier, unless an exception applies. The first phase of the program begins on January 1, 2011, in nine CBAs for nine product categories.

In order for Medicare to make payment, where appropriate, for claims subject to competitive bidding, it is important that all providers and suppliers who provide DMEPOS affected by the program use the appropriate modifiers on each claim.

Note: To ensure accurate claims processing, it is critically important for suppliers to submit each claim using the billing number/ National Provider Identifier (NPI) of the location that furnished the item or service being billed.

Competitive Bidding Modifiers
New Healthcare Common Procedure Coding System (HCPCS) modifiers have been developed to facilitate implementation of various policies that apply to certain competitive bidding items. The new HCPCS modifiers used in conjunction with claims for items subject to competitive bidding are defined as follows:
- J4-DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished by a Hospital Upon Discharge.
- KG- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1.
- KK- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2.
- KW- DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3.
- KY-DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 4.
- KL-DMEPOS Item Delivered via Mail.
- KV-DMEPOS Item Subject to DMEPOS Competitive Bidding Program that is Furnished as Part of a Professional Service.
- KT-Beneficiary Resides in a Competitive Bidding Area and Travels Outside that Competitive Bidding Area and Receives a Competitive Bid Item.

Suppliers should submit claims for competitive bidding items using the appropriate HCPCS code and corresponding competitive bidding modifier in effect during a contract period. The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The modifiers associated with particular competitive bid codes, such as the KG, KK, or KL modifiers, are listed by competitive bid product category on the single payment amount public use charts found under the supplier page at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the Competitive Bidding Implementation Contractor (CBIC) website.

Failure to use or inappropriate use of a competitive bidding modifier on a competitive bidding claim leads to claims denial. The use of a competitive bidding modifier does not supersede
existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Another modifier was developed to facilitate implementation of DMEPOS fee schedule policies that apply to certain competitive bidding items that were bid prior to July 1, 2008, under the initial Round I of the DMEPOS Competitive Bidding Program. The KE modifier is defined as follows:

- KE-DMEPOS Item Subject to DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment.

How to Use the Modifiers

Hospitals Providing Walkers and Related Accessories to Their Patients on the Date of Discharge - The J4 Modifier

Hospitals may furnish walkers and related accessories to their own patients for use in the home during an admission or on the date of discharge and receive payment at the applicable single payment amount, regardless of whether the hospital is a contract supplier or not. Please note that separate payment is not made for walkers furnished by a hospital for use in the hospital, as payment for these items is included in the Part A payment for inpatient hospital services.

To be paid for walkers as a non-contract supplier, the hospital must use the modifier J4 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. Under this exception, hospitals are advised to submit the claim for the hospital stay before or on the same day as they submit the claim for the walker to ensure timely and accurate claims processing.

Hospitals that are located outside a CBA that furnish walkers and/or related accessories to travelling beneficiaries who live in a CBA must affix the J4 modifier, to claims submitted for these items.

The J4 modifier should not be used by contract suppliers.

Modifiers for HCPCS Accessory or Supply Codes Furnished in Multiple Product Categories - The KG, KK, KU, and KW Modifiers

The KG, KK, KU, and KW modifiers are modifiers that identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories or when the same code can be used to describe both competitively and non-competitively bid items. For example, HCPCS code E0981 Wheelchair Accessory, Seat Upholstery, Replacement Only, Each is found in both the standard and complex rehabilitative power wheelchair competitive bidding product categories. Contract suppliers for the standard power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a standard power wheelchair shall submit E0981 claims using the KG modifier. Contract suppliers for the complex rehabilitative power wheelchair product category as well as other suppliers submitting claims for this accessory item furnished for use with a complex power wheelchair shall submit claims for E0981 using the KK modifier. Another example of the use of the KG modifier is with code A4636 Replacement, Handgrip, Cane, Crutch, or Walker, Each. Contract suppliers for the walkers and related accessories product category in addition to other suppliers submitting claims for this accessory item when used with a walker shall submit A4636 claims using the KG modifier.

All suppliers that submit claims for beneficiaries that live in a CBA, including contract, non-contract, and grandfathered suppliers, should submit claims for competitive bid items using the above mentioned competitive bidding modifiers. Non-contract suppliers that furnish competitively bid supply or accessory items to traveling beneficiaries who live in a CBA must use the appropriate KG or KK modifier with the supply or accessory HCPCS code when submitting their claim. Also, grandfathered suppliers that furnish competitively bid accessories or supplies used in conjunction with a grandfathered item must include the appropriate KG or KK modifier when submitting claims for accessory or supply codes. The KG and KK modifiers are used in the Round I Rebid of the competitive bidding program as pricing modifiers and the KU and KW modifiers are reserved for future program use.

The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers (i.e. KG, KK, KL) are denoted in the single payment amount public use charts found under the supplier page at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the CBIC website.

Purchased Accessories & Supplies For Use With Grandfathered Equipment - The KY Modifier

Non-contract grandfathered suppliers must use the KY modifier on claims for CBA-residing beneficiaries with dates of service on or after January 1, 2011, for purchased, covered accessories or supplies furnished for use with rented grandfathered equipment. (However, effective October 1, 2011, the KY modifier is not required on these claims. Any claims submitted after September 30, 2011 with the KY modifier will be denied. For more details, see article MM7389 at http://www.cms.gov/MLNMattersArticles/downloads/MM7389.pdf on the CMS website.) The following HCPCS codes are the codes for which use of the KY modifier is authorized for dates of service January 1-September 30, 2011:

- Hospital Beds and Related Accessories – E0271, E0272, E0280, and E0310; and
- Walkers and Related Accessories – E0154, E0156, E0157 and E0158

Until notified otherwise, grandfathered suppliers that submit claims for the payment of the aforementioned purchased accessories and supplies for use with grandfathered equipment should submit the applicable single payment amount for the accessory or supply as their submitted charge on the claim. The single payment amounts for items included in the Round 1 Rebid of the DMEPOS Competitive Bidding Program can be found under the Single Payment Amount tab on the following website: http://www.dmecompetitivebid.com/SPA on the Internet.. Non-contract
grandfathered suppliers should be aware that purchase claims submitted for these codes without the KY modifier will be denied. Also, claims submitted with the KY modifier for HCPCS codes other than those listed above will be denied.

After the rental payment cap for the grandfathered equipment is reached, the beneficiary must obtain replacement supplies and accessories from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the supplies and accessories once the rental payment cap is reached.

Mail Order Diabetic Supplies - The KL Modifier
Contract suppliers must use the KL modifier on all claims for diabetic supply codes that are furnished via mail order. Non contract suppliers that furnish mail order diabetic supplies to beneficiaries who do not live in CBAs must also continue to use the KL modifier with these codes. Suppliers that furnish mail-order diabetic supplies that fail to use the HCPCS modifier KL on the claim may be subject to significant penalties. For claims with dates of service prior to implementation of a national mail order competitive bidding program, the KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence via mail order or are obtained from a local supplier storefront. Once a national mail order competitive bidding program is implemented, the definition for mail order item will change to include all diabetic supply codes delivered to the beneficiary via any means. At this time, the KL modifier will need to be used for all diabetic supply codes except for claims for items that a beneficiary or caregiver picks up in person from a local pharmacy or supplier storefront.

Physicians and Treating Practitioners Who Furnish Walkers and Related Accessories to their Own Patients but Who Are Not Contract Suppliers - The KV Modifier
The KV modifier is to be used by physicians and treating practitioners who are not contract suppliers and who furnish walkers and related accessories to beneficiaries in a CBA. Walkers that are appropriately furnished in accordance with this exception will be paid at the single payment amount.

To be paid for walkers as a non-contract supplier, physicians and treating practitioners should use the modifier KV 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. On the claim billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), the walker line item must have the same date of service as the professional service office visit billed to the Part A/Part B MAC. Physicians and treating practitioners are advised to submit the office visit claim and the walker claim on the same day to ensure timely and accurate claims processing.

Physicians and treating practitioners who are located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries who live in a CBA must affix the KV modifier to claims submitted for these items.

The KV modifier should not be used by contract suppliers.

Traveling Beneficiaries - The KT Modifier
Suppliers must submit claims with the KT modifier for non-mail-order DMEPOS competitive bidding items that are furnished to beneficiaries who have traveled outside of the CBA in which they reside. If a beneficiary who lives in a CBA travels to an area that is not a CBA and obtains an item included in the competitive bidding program, the non contract supplier must affix this modifier to the claim. Similarly, if a beneficiary who lives in a CBA travels to a different CBA and obtains an item included in the competitive bidding program from a contract supplier for that CBA, the contract supplier must use the KT modifier.

SNFs and NPs that are not contract suppliers and are not located in a CBA must also use the KT modifier on claims for enteral nutrition items furnished to residents with a permanent home address in a CBA. SNF or NF claims that meet these criteria and are submitted without the KT modifier will be denied.

Claims for mail-order competitive bidding diabetic supplies submitted with the KT modifier will be denied. Contract suppliers must submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary’s permanent home address.

To determine if a beneficiary permanently resides in a CBA, a supplier should follow these two simple steps:

1. Ask the beneficiary for the ZIP code of his or her permanent residence. This is the address on file with the Social Security Administration (SSA).
2. Enter the beneficiary’s ZIP code into the CBA finder tool on the home page of the Competitive Bidding Implementation Contractor (CBIC) website, found at http://www.dmecompetitivebid.com on the Internet.

The KE Modifier
Section 154(a)(2) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 mandated a fee schedule covered item update of -9.5% for 2009 for items included in the Round I of the DMEPOS Competitive Bidding Program. This covered item update reduction to the fee schedule file applies to items furnished on or after January 1, 2009, in any geographical area. In order to implement the covered item update required by MIPPA, the KE modifier was added to the DMEPOS fee schedule file in 2009 to identify Round I competitively bid accessory codes that could be used with both competitively bid and non-competitively bid base equipment. All suppliers must use the KE modifier on all Part B Fee-For-Service claims to identify when a Round I bid accessory item is used with a non-competitively bid base item (an item that was not competitively bid prior to July 2008).

For example, HCPCS code E0950 Wheelchair Accessory, Tray, Each can be used with both Round I competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0098). All suppliers must use the KE modifier with the accessory code to identify when E0950 is used in conjunction with a non-competitively bid manual wheelchair (K0001 thru
K0009) or a miscellaneous power wheelchair (K0898). The KE modifier should not be used with competitive bid accessory HCPCS codes that are used with any competitive bid base item that was included in the initial Round I of the Competitive Bidding Program prior to July 1, 2008. Therefore, in the above example, KE is not valid for use with accessory code E0950 when used with standard power wheelchairs, complex rehabilitative power wheelchairs (Group 2 or Group 3), or any other item selected for competitive bidding prior to July 1, 2008.

For beneficiaries living in competitive bid areas on or after January 1, 2011, suppliers should not use the KE modifier to identify competitively bid accessories used with base equipment that was competitively bid under the Round I Rebid Competitive Bidding Program. Rather, such claims should be submitted using the appropriate KG or KK modifiers as identified on the single payment amount public use charts found under the supplier page at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the CBIC website.

Following is a chart that illustrates the relationship between the competitive bid modifiers (KG, KK, KU, and KW) and the KE modifier using competitively bid accessory code E0950:

<table>
<thead>
<tr>
<th>Accessory Code E0950 used with KG</th>
<th>Base Code Competitive Bid Status</th>
<th>Claim for a Beneficiary who Permanently Lives in a CBA</th>
<th>Claim for a Beneficiary who Permanently Lives Outside a CBA*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Wheelchair (K0001 thru K0009) or Miscellaneous Power Wheelchair (K0898)</td>
<td>Non-Bid</td>
<td>Bill with KE modifier</td>
<td>Bill with KE modifier</td>
</tr>
<tr>
<td>Standard Power Wheelchair (K0813 thru K0829)</td>
<td>Bid in Round 1 and the Round 1 Rebid</td>
<td>Bill with KG modifier</td>
<td>Bill without KE modifier</td>
</tr>
<tr>
<td>Complex Rehabilitative Group 2 Power Wheelchair (K0833 thru K0843)</td>
<td>Bid in Round 1 and the Round 1 Rebid</td>
<td>Bill with KK modifier</td>
<td>Bill without KE modifier</td>
</tr>
<tr>
<td>Complex Rehabilitative Group 3 Power Wheelchair (K0848 thru K0854)</td>
<td>Bid in Round 1</td>
<td>Bill without KE, KK or KG modifier</td>
<td>Bill without KE modifier</td>
</tr>
</tbody>
</table>

* The competitive bid modifiers (KG, KK, KU, and KW) are only used on claims for beneficiaries that live in a Competitive Bidding Area (CBA).

**Additional Information**

The Medicare Learning Network® (MLN) has prepared several fact sheets for beneficiaries, referred agents, and general fact sheets for non-contract suppliers and referral agents. They are all available, free of charge, at http://www.cms.gov/MLNProducts/downloads/DMEPOS_Competitive_Bidding_Factsheets.pdf on the Internet.

For more information about the DMEPOS Competitive Bidding Program, including a list of the first nine CBAs and items included in the program, visit http://www.cms.gov/DMEPOSCompetitiveBid on the Centers for Medicare & Medicaid Services (CMS) dedicated website.

Information for contract suppliers can be found at the CBIC website at http://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

Beneficiary-related information can be found at http://www.medicare.gov on the Internet.

**News Flash Items**

Looking for the latest Medicare Fee-For-Service (FFS) information? Then subscribe to a Medicare FFS Provider listserv that suits your needs! For information on how to register and start receiving the latest news, go to http://www.cms.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

The National Government Services, Inc. (NGS) Common Electronic Data Interchange (CEDI) which serves Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claim submissions to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) is currently migrating Trading Partners (TPs) from dial-up access to Network Service Vendors (NSVs). The NSVs are not affiliated with the Centers for Medicare & Medicaid Services (CMS) or the DME MAC nor is any NSV specifically endorsed by CMS or the DME MAC. CMS continues to find ways to reduce security risks. As CMS progresses toward a more secure CMS network, this approach is one way to ensure your Medicare data is protected. If you submit claims directly to CEDI and have not made the switch to an NSV, now is the time to reach out to a NSV to avoid any disruption in sending your claims. If you send your DME claims through a clearinghouse or third party biller, contact them to make sure they have made or will be making the switch. Please contact the National Government Services CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 1.866.311.9184 if you have any additional questions regarding this initiative. To stay informed of all CEDI updates, visit the CEDI website at http://www.ngscedi.com/ and sign up for the CEDI ListServ by selecting the ListServ Registration Link. Select “Join” and follow the prompts to subscribe to the CEDI ListServ.

The “Medicare Quarterly Provider Compliance Newsletter” is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. This publication is issued on a quarterly basis and highlights the “top” issues of that particular quarter. An archive and searchable index of current and previously-issued newsletters is available at http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf on the Centers for Medicare & Medicaid (CMS) website.

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

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

**Did you know that Medicare provider enrollment application forms can be completed on your computer?** This means that you can fill out the information required by typing into the open fields while the form is displayed on your computer monitor. Filling out the forms this way before printing, signing, and mailing means more easily-readable information—which means fewer mistakes, questions, and delays when your application is processed. Be sure to make a copy of the signed form for your records before mailing. You will find the Medicare provider enrollment application forms available at [http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp](http://www.cms.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp) on the Centers for Medicare & Medicaid Services website.

**Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and the National Council for Prescription Drug Program’s (NCPDP) version D.0 standards as of January 1, 2012.** To facilitate the implementation, Medicare has designated Calendar Year 2011 as the official 5010/D.0 transition year. As such, Medicare Administrative Contractors (MACs) will be testing with their trading partners throughout Calendar Year 2011. Medicare encourages its providers, vendors, clearinghouses, and billing services to schedule testing with their local MAC as soon as possible. CMS also encourages you to stay current on 5010/D.0 news and helpful tools by visiting [http://www.cms.gov/Versions5010andD0/](http://www.cms.gov/Versions5010andD0/) on its website. Test early, Test often!

**If you are a provider or supplier that furnishes the technical component of Advanced Diagnostic Imaging (ADI) services and bill Medicare under the Physician Fee Schedule for these services, you should know that you must be accredited by Sunday, January 1, 2012.** Those not accredited by that deadline will not be able to bill Medicare until they become accredited. For more information about ADI Accreditation, including details of the accreditation process and the organizations approved by the Centers for Medicare & Medicaid Services (CMS) to grant accreditation, please visit [http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp](http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp) on the CMS website. An MLN Special Edition Article (SE1122) – “Important Reminders about Advanced Diagnostic Imaging (ADI) Accreditation Requirements” – has also been published and is available at [http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.pdf](http://www.CMS.gov/MLNMattersArticles/Downloads/SE1122.pdf) on the CMS website.

**The July 2011 issue of the “Medicare Quarterly Provider Compliance Newsletter” is now available in downloadable format from the Medicare Learning Network at [http://www.CMS.gov/MLNProducts/downloads/Comp_Newsletter_ICN903687.pdf](http://www.CMS.gov/MLNProducts/downloads/Comp_Newsletter_ICN903687.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.** This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. Please visit [http://www.CMS.gov/MLNProducts/downloads/Comp_Newsletter_ICN903687.pdf](http://www.CMS.gov/MLNProducts/downloads/Comp_Newsletter_ICN903687.pdf) to download, print, and search newsletters from previous quarters.

**Revised! The publication titled “The National Provider Identifier (NPI): What You Need to Know” (revised February 2011), is now available in downloadable format.** This booklet was created to help you become more familiar with the NPI (established by final rule on January 23, 2004). Covered entities under HIPAA are required by regulation to use NPIs to identify healthcare providers in HIPAA standard transactions. This publication may be downloaded from [http://www.CMS.gov/MLNProducts/downloads/NPIBooklet.pdf](http://www.CMS.gov/MLNProducts/downloads/NPIBooklet.pdf) on the Centers for Medicare & Medicaid Services (CMS) website.

**The Centers for Medicare & Medicaid Services (CMS) has posted 18 new FAQs about HIPAA version 5010 implementation, and one PDF document containing 27 Q&As specific to the Wednesday, March 30, CMS-hosted 5010 national provider teleconference on provider testing and readiness.** To review these FAQs, visit the CMS FAQ database at [http://questions.CMS.hhs.gov](http://questions.CMS.hhs.gov) and search for “5010.” For more information, you can also go to [http://www.CMS.gov/Downloads/033011_National_Call_Resource_Mailbox_Qs_and_As.pdf](http://www.CMS.gov/Downloads/033011_National_Call_Resource_Mailbox_Qs_and_As.pdf) on the CMS website.

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

**The Centers for Medicare & Medicaid Services (CMS) has posted online the Monday, June 20, letter from CMS Administrator, Donald M Berwick, MD, that highlights opportunities for providers, Medicare beneficiaries, and patients not covered by Medicare as a result of the Affordable Care Act.**
letter was sent to Medicare Fee-For-Service providers by the Medicare Administrative Contractors (MACs) during the week of Monday, June 20, and can be found at [http://www.CMS.gov/MLNProducts/35 PrevenitiveServices.asp](http://www.CMS.gov/MLNProducts/35 PrevenitiveServices.asp) on the CMS website.

The Medicare Learning Network® (MLN) is interested in what you have to say. Regardless of whether you have an MLN account or not, you can evaluate the MLN products, services, and activities that you have participated in, received, or downloaded. This MLN page offers a new anonymous evaluation function that allows you to complete an evaluation without logging in. Visit the MLN Opinion Page found at [http://www.CMS.gov/MLNProducts/85 Opinion.asp](http://www.CMS.gov/MLNProducts/85 Opinion.asp) and click on “MLN Opinion Page” in the “Related Links Inside CMS” section at the bottom of the page. Click on the underlined title of the product, service, or activity you want to evaluate and click on the “Take the anonymous evaluation for this product” link that will appear on the right-hand side. A new window will open containing the product evaluation.

**The Version 5010 compliance date – January 1, 2012 – is fast approaching. Are you prepared for the transition?** Medicare Fee-for-Service (FFS) trading partners are encouraged to contact their Medicare Administrative Contractors (MACs) now and facilitate testing to gain a better understanding of MAC testing protocols and the transition to Version 5010. To assist in this effort, the Centers for Medicare & Medicaid Services (CMS), in conjunction with the Medicare FFS Program, announce a National 5010 Testing Week to be held August 22 through August 26, 2011. National 5010 Testing Week is an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs. For more information on Version 5010, please visit the CMS dedicated 5010 website at [http://www.CMS.gov/Version5010andD0](http://www.CMS.gov/Version5010andD0) on the CMS website.

Is your organization preparing for a smooth transition to ICD-10 on October 1, 2013? The Centers for Medicare & Medicaid Services (CMS) ICD-10 website at [http://www.cms.gov/icd10](http://www.cms.gov/icd10) is a valuable resource to help you prepare for the U.S. healthcare industry’s change from ICD-9 to ICD-10 for medical diagnosis and inpatient procedure coding. Check back frequently for the latest news, resources, compliance timelines, and teleconference information. While you are visiting the site, sign up for the CMS ICD-10 Industry Email Updates to receive the latest information on the transition and new website content.

The Medicare Learning Network® has released a new CD-ROM titled “The Interactive Guide to the Medicare Learning Network.” This CD-ROM allows for a two-way flow of information between FFS providers and the MLN. Providers and other healthcare professionals can link directly from the products described on the CD-ROM to the MLN webpages and the MLN Catalog of Products. Once there, users can then conveniently download and print copies of the most up-to-date and accurate MLN products. To order the CD-ROM through the MLN Product Ordering System, visit [http://www.CMS.gov/MLNProducts](http://www.CMS.gov/MLNProducts) on the CMS website.

A new publication titled “Signature Requirements” is now available in downloadable format from the Medicare Learning Network® at [http://www.CMS.gov/MLNProducts/downloads/Sigature_Requirements_Fact_Sheet_ICN905364.pdf](http://www.CMS.gov/MLNProducts/downloads/Sigature_Requirements_Fact_Sheet_ICN905364.pdf) on the CMS website. This fact sheet is designed to provide education on Signature Requirements to healthcare providers, and includes information on the documentation needed to support a claim submitted to Medicare for medical services.

The “World of Medicare” Web-Based Training (WBT) course has been revised (as of January 2011). It is designed for healthcare professionals who want to understand the fundamentals of the Medicare program, and covers Medicare Part A, Part B, Part C, and Part D; identifying Medicare beneficiary health insurance options; eligibility and enrollment; as well as recognizing how Medigap and Medicaid work with the Medicare program. This WBT course offers continuing education credits; please see the course description for details. To access the training course, visit [http://www.CMS.gov/MLNGenInfo](http://www.CMS.gov/MLNGenInfo) on the Centers for Medicare & Medicaid Services (CMS) website, scroll to “Related Links Inside CMS,” select “Web-Based Training (WBT) Modules,” and then select “World of Medicare (Developed: January 2010/Revised January 2011)” from the list of trainings provided.

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

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**CHECK IT OUT!**

**The CGS DME MAC Jurisdiction C Provider Outreach & Education page on Facebook®**

Become a fan and get all of the latest DME MAC Provider Outreach & Education (POE) information and more on the CGS DME POE page on Facebook® at: [http://www.facebook.com/cignagovernmentservices](http://www.facebook.com/cignagovernmentservices)

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### DME MAC Jurisdiction C Contact Information

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

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