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From the **Medical Director**

**Reminder: Submitting Additional Documentation**

Recently CIGNA Government Services (CGS) implemented edits for various items of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). As a result, suppliers are receiving letters requesting submission of additional documentation to support the medical necessity. For some of these claims, suppliers have been submitting hundreds of pages per claim, a large percentage of which do not pertain to the claim issue/DMEPOS item in question. This extra information, such as copies of the local coverage determination (LCD), manual citations or medical records unrelated to the item in question, is unnecessary and potentially hinders the rendering of an accurate claim decision.

Suppliers are reminded that only documentation directly related to supporting the coverage and coding requirements outlined in the additional documentation request letter and/or local coverage determination (LCD) requirements should be submitted in support of a claim. According to the Health Insurance Portability and Accountability Act (HIPAA), “When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.” CGS asks that suppliers responding to additional documentation requests carefully review the information being submitted to CGS and refrain from sending extraneous documents.

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

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**Coverage & Billing**

**Immunosuppressive Drugs Coverage Requirements**

During recent claim reviews for Immunosuppressive Drugs, the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) noted that suppliers are appending the KX modifier inappropriately. Specifically, suppliers are using the KX modifier when a beneficiary received their transplant prior to Medicare Part A enrollment. According to the Immunosuppressive Drugs Policy Article, coverage of immunosuppressive drugs requires that, in part:

- The patient was enrolled in Medicare Part A at the time of the transplant; and,
- The patient is enrolled in Medicare Part B at the time that the drugs are dispensed.

Immunosuppressive drugs provided to Medicare beneficiaries whose transplant occurred prior to their enrollment in Medicare Part A should not be billed to the DME MAC. For those patients, the drugs may be eligible for coverage under Medicare Part D.
In order to use the KX modifier on a claim line for immunosuppressive drugs, the supplier must have documentation on file to support that the coverage requirements are met. As noted in the local coverage determination (LCD) for Immunosuppressive Drugs Documentation Section:

**KX and GY MODIFIERS:**

The KX modifier must be added to the claim line(s) for the immunosuppressive drug(s) only if:

A. The supplier obtains from the ordering physician the date of the organ transplant; and,
B. The beneficiary was enrolled in Medicare Part A at the time of the organ transplant (whether or not Medicare paid for the transplant); and,
C. The transplant date precedes the date of service on the claim.

If these three requirements are not met, the KX modifier must not be added to the claim.


**Power Wheelchair Rental - Frequently Asked Questions**

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.

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

   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. **How will the “look back” period affect the review of PWCS?**

   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.

3. **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?**

   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.

4. **If a patient who is renting a PWC moves, is a new in-home assessment required?**

   No.

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?**

   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.

6. **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?**

   Standard capped rental rules for beginning a new rental period will 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.).

7. **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?**

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

8. **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?**

   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.
Oral Antiemetic Drugs - Coverage Reminder

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received questions regarding the coverage requirements in the Oral Antiemetic Drugs (Replacement for Intravenous Drugs) local coverage determination (LCD) and related policy article. Coverage of oral antiemetic drugs is a specific Medicare benefit category found in the Social Security Act, Title XVIII, Section 1861(s)(2)(T) with further instructions for coverage in the Medicare Claims Processing Manual (CMS Internet-Only Publication 100-4, Chapter 17, Section 80.2).

Questions recently raised relate to the requirement that the oral antiemetic must be initiated within two (2) hours of the administration of the chemotherapeutic agent. This means that the first dose of the oral antiemetic drug or drugs (if part of a multi-drug regimen), must be administered to the beneficiary within 2 hours of initiation of the cancer chemotherapeutic regimen. This does not mean that the pharmacy must dispense the drug or fill a prescription within 2 hours of administration of the drug(s). In addition, the amount dispensed must not exceed the maximum dosing time period limitation of 24 or 48 hours as described in the Healthcare Common Procedure Coding System (HCPCS) code descriptor for each drug.

Suppliers should refer to the local coverage determination and related policy article for Oral Antiemetic Drugs (Replacement for Intravenous Drugs) at http://www.cms.gov/mcd/search.asp?from2=search.asp& for additional coverage, coding and documentation requirements.

Continuous Passive Motion (CPM) Devices - Accessories Reminder

During a recent review of claims for code E0935 (Continuous Passive Motion Exercise Device For Use on Knee Only) it was noted that suppliers are using codes E0188 (Synthetic Sheepskin Pad) or code E0189 (Lambswool Sheepskin Pad, Any Size) to bill for the soft interface used with code E0935. Suppliers are reminded that code E0935 is in the frequently serviced category and can be allowed for a maximum of 21 days rental. All supplies (e.g., interface material) and accessories are included in the rental payment. There is no separate billing for the interface material or other accessories.

Suppliers should refer to the Continuous Passive Motion Devices National Coverage Determination (NCD) in National Coverage Determinations Manual (CMS Internet-Only Manual, Publication 100-3, Chapter 1, Part 4, Section 280.1) and the Medicare Claims Processing Manual (CMS Internet-Only Manual, Publication 100-4, Chapter 30, Section 30.2.1) for additional coverage, coding and documentation requirements.

HCPCS Code E0571 – Invalid

Effective for dates of service on or after February 4, 2011, Healthcare Common Procedure Coding System (HCPCS) code E0571 (Aerosol compressor, battery powered, for use with small volume nebulizer) will be invalid for claim submission to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Suppliers providing battery-powered aerosol compressors should bill existing HCPCS code E0570 (Nebulizer, with compressor).

Refer to the Nebulizers local coverage determination (LCD) at http://www.cms.gov/mcd/search.asp?from2=search.asp& for additional coverage, coding and documentation requirements.

Products previously coded E0571 by the Pricing, Data Analysis and Coding (PDAC) contractor will be end dated on February 3, 2011 and will be listed with E0570 with an effective date of February 4, 2011. These products will be listed on the Product Classification List which is located on DME Coding System (DMECS). DMECS is located on the PDAC website, www.dmepdac.com.

Power Mobility Devices - Detailed Product Descriptions - Implications of Fee Schedule and Payment Policy Changes

In order for a power mobility device (PMD) and related options and accessories to be covered, a detailed product description (DPD) signed and dated by the ordering physician must be obtained by the supplier prior to delivery. Two of the required elements of the DPD are the supplier’s submitted charge and the Medicare fee schedule allowance. Medicare fee schedule allowances typically change with a new calendar year and may be revised at other times. If the supplier’s submitted charge and fee schedule allowance are correct at the time that the DPD is signed by the physician but change prior to delivery of the PMD, the supplier is not required to obtain a new DPD. Also, if the DPD was completed in 2010 based on the submitted charge and fee schedule allowance for a purchased PMD, a new DPD is not required if the PMD is delivered in 2011 and billed as a rental. (Refer to Power Mobility Devices LCD for additional information relating to DPDs.)

Heating Pads and Heat Lamps - Draft Medical Policy Finalized

The draft Local Coverage Determination and Policy Article for Heating Pads and Heat Lamps has been finalized. The medical policy is effective for claims with dates of service on or after April 1, 2011.

Products that are currently coded E0210, E0215, E0217, or E0249 by the Pricing, Data Analysis and Coding (PDAC) contractor and are listed in the DME Coding System (DMECS) Product Classification List on the PDAC website will be end-dated on March 31, 2011. Although Coding Verification Review by the PDAC is not required for suppliers to bill these products, manufacturers who want their product(s) listed in DMECS after April 1, 2011 will need to submit a new application.
KX Modifier – Requirements for Use

The narrative description for the KX modifier is, “Requirements specified in the medical policy have been met.”

The primary use of the KX modifier is to enable the DME MAC to perform automated medical review of claims. Information relating to coverage criteria that can be submitted with electronic claims is limited. Among the elements that can be used as screening tools for automated review are ICD-9 diagnosis codes, Certificates of Medical Necessity (CMNs), units of service, and dates of service. However, the more complex coverage criteria in many medical policies cannot be assessed using that information.

The KX modifier serves as an attestation by the supplier that the requirements for its use that are defined in the particular Local Coverage Determination (LCD) are true for that specific beneficiary. It must not be added indiscriminately just “because it is needed to get the claim paid”.

As the description of the KX modifier indicates, requirements for its use vary from policy to policy. In some policies, the modifier pertains to all HCPCS codes; in other policies, it applies to only select codes. In some policies, use of the KX modifier refers to very limited information (e.g., in the Glucose Monitors policy, whether the patient uses insulin); whereas in other policies, it attests that multiple criteria have been met (e.g., Power Mobility Devices). In some policies, absence of the KX modifier results in a medical necessity denial; in other policies, the lack of the modifier results in a statutorily non-covered denial.

In the following policies, the instructions for use of the KX modifier clearly specify that the supplier must have the documentation (e.g., copies of the patient's medical record, test reports, etc.) in their files before they may submit a claim line with the modifier. If they do not, the modifier must not be added.

- Ankle-Foot/ Knee-Ankle-Foot Orthoses
- Cervical Traction Devices
- Knee Orthoses
- Patient Lifts
- Pressure Reducing Support Surfaces – Group 1
- Pressure Reducing Support Surfaces – Group 2
- Pressure Reducing Support Surfaces – Group 3
- Respiratory Assist Devices
- Walkers

In the following policies, the requirements for use of the KX modifier do not specify that the supplier must have the documentation in their files before they submit the claim, saying instead that the information must be available “upon request”. For these policies, at the very least, the supplier must have phone contact with the physician's office or use other means to verify that all of the specified coverage criteria have been met. However, because multiple audits have shown that information verifying coverage is often not present in the physician's records and may be particularly difficult to obtain months or years after the item is provided; the DME MAC encourages suppliers to obtain the documentation supporting medical necessity in advance of claim submission and retain it in their files.

- Automatic External Defibrillators
- ComMODEs
- External Infusion Pumps
- Glucose Monitors
- High Frequency Chest Wall Oscillation Devices
- Hospital Beds
- Immunosuppressive Drugs
- Manual Wheelchair Bases
- Nebulizers
- Negative Pressure Wound Therapy Pumps
- Oral AntiEmetic Drugs
- Orthopedic Footwear
- Positive Airway Pressure Devices
- Power Mobility Devices
- Refractive Lenses
- Therapeutic Shoes for Persons with Diabetes
- Transcutaneous Electrical Nerve Stimulators
- Urological Supplies
- Wheelchair Options and Accessories
- Wheelchair Seating

Adding the KX modifier without ascertaining that all the requirements specified in the policy have been met could be viewed as filing a false claim and potential abuse of the Medicare program.

It is imperative that suppliers review the Documentation Requirements section of each LCD in order to fully understand the criteria that must be met for the proper use of the KX modifier. Obtaining physician records, test reports, and other documents is the best means of assuring that all of the information needed to support use of the KX modifier is present in the event of an audit.

Visit http://www.cignagovernmentservices.com to view a Medicare Minute KX Modifier video that illustrates the importance of using this modifier correctly. Our KX Tool also on our website is an easy to use table of LCD names with corresponding policy-specific meaning of KX modifier usage.

Resubmitting Claims with Upgrade Modifiers

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) issued bulletin articles regarding the use of upgrade modifiers in conjunction with HCPCS codes subject to...
the elimination of least costly alternative (LCA). For certain items that were previously subject to LCA, suppliers will now receive a not reasonable and necessary denial. The article indicated that further instructions would be forthcoming concerning the options that a supplier has if a claim for an item previously subject to LCA is submitted without upgrade modifiers, is subsequently denied as not reasonable and necessary and the supplier decides that it would like to utilize the upgrade modifiers.

For items that were previously subject to LCA, suppliers have the option of resubmitting the claim using the upgrade modifiers and the code for the covered medically necessary item rather than exercising the option of Appeals. For example, a supplier submits a claim after February 4, 2011 for code E0265 (fully electric hospital bed) and the claim is denied as not reasonable and necessary. That claim may be resubmitted with code E0265 and the appropriate modifiers on Line 1 and code E0260 and the appropriate modifiers on Line 2. Resubmitting the claim in this fashion will not result in a conflict with the original code E0265 claim and subsequent duplicate claim denial.

These resubmission instructions apply only to items previously subject to LCA payment policy that now receive not reasonable and necessary denials. Other items receiving reasonable and necessary denials must follow the usual redeterminations process.

For additional information on the use of upgrade modifiers, see the bulletin article entitled Use of Upgrade Modifiers published on the CIGNA Government Services (CGS) ListServ and website on December 16, 2010 at: http://www.cignagovernmentservices.com/

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

MLN Matters® Number: MM7064 Revised
Related Change Request (CR) #: 7064
Related CR Release Date: January 14, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2134CP
Implementation Date: January 3, 2011

Note: This article was revised on January 18, 2011. To reflect the revised CR 7064 that was issued on January 14, 2011. In this article, the CR release date, transmittal number, and the Web address for accessing CR 7064 were revised. All other information is the same.

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

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

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

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

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

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

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

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

Outlier Adjustment

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

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

1. ESRD-related drugs and biologicals that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
2. ESRD-related laboratory tests that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B;
3. Medical/surgical supplies, including syringes, used to administer ESRD-related drugs that were or would have been, prior to January 1, 2011, separately billable under Medicare Part B; and
4. Renal dialysis service drugs that were or would have been, prior to January 1, 2011, covered under Medicare Part D, notwithstanding the delayed implementation of ESRD-related oral-only drugs effective January 1, 2014.

Note: Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and telehealth services, are not considered outlier services.

Facility-level Adjustments

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

Training Add-On

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

Adjustments Specific to Pediatric Patients

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

Treatments furnished to pediatric patients:

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

Note: Pediatric dialysis treatments are not eligible for the low-volume adjustment.

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

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

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

For Calendar Year (CY) 2011, CMS will continue to update the basic case-mix composite payment system for purposes of determining the composite rate portion of the blended payment amount. CMS updated the composite payment rate, the drug add-on adjustment to the composite rate, the wage index adjustment, and the budget neutrality adjustment.

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

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

During the transition, the labor-related share of the case-mix adjusted composite payment system will remain 0.5371.

The payment rate for a dialysis treatment is determined by wage adjusting the base rate and then applying any applicable:
• Patient-level adjustments;
• Outlier adjustments;
• Facility-level adjustments; and
• Training add-on payments (adjusted for area wage levels)

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

The ESRD PRICER will provide the payment for existing composite rate, the new ESRD PPS payment rate, and the outlier payment (when applicable). These reimbursement amounts must be blended during a transition period for all ESRD facilities except those facilities opting out of the transition and electing to be paid 100 percent of the payment amount under the new ESRD PPS.

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

Three New Adjustments Applicable to the Adult Rate

1. Comorbid Adjustments: The new ESRD PPS provides for 3 categories of chronic comorbid conditions and 3 categories for acute comorbid conditions. A single adjustment will be made to claims containing one or more of the comorbid conditions. The highest comorbid adjustment applicable will be applied to the claim. The acute comorbid adjustment may be paid no greater than 4 consecutive months for any reported acute comorbid condition, unless there is a reoccurrence of the condition. The 3 chronic comorbid categories eligible for a payment adjustment are:
   - Hereditary hemolytic and sickle cell anemia;
   - Monoclonal gammopathy (in the absence of multiple myeloma); and
   - Myelodysplastic syndrome.

The 3 acute comorbid categories eligible for a payment adjustment are:
   - Bacterial Pneumonia;
   - Gastrointestinal Bleeding; and
   - Pericarditis.

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

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

Change in Processing Home Dialysis Claims

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

Therefore, all home dialysis claims:
   • Must be submitted by a renal dialysis facility and
   • Will be processed as Method I claims.

Note: CR 7064 instructs the DME MACs to stop separate payment to suppliers for Method II home dialysis items and services for claims with dates of service on or after January 1, 2011. Medicare will, however, allow separate billing for ESRD supply HCPCS codes (as shown on attachment 4 of CR 7064) by DME suppliers when submitted for services not related to the beneficiary’s ESRD dialysis treatment and such services are billed with the AY modifier.

Consolidated Billing

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

Other Billing Reminders

• Note that with the ESRD PPS changes, Medicare systems will also reject any lines reporting revenue code 0880 as of January 1, 2011. These rejections will be made with remittance advice remark code (RARC) M81 (You are required to code to the highest level of specificity), and assign a group code of CO (provider liability) to such lines.

• Medicare will return claims to the provider with dates of service spanning 2010 and 2011.

• Telehealth services billed with HCPCS Q3014, preventive services covered by Medicare, and blood and blood services are exempt from the ESRD PPS and will be paid based on existing payment methodologies.

• When claims are received without the AY modifier for items and services that are not separately payable due to the ESRD PPS consolidated billing process, the claims will be returned with claim adjustment reason code (CARC) 109 (Claim not
Elimination of Lump Sum Purchase Payment for Standard Power Wheelchairs Furnished on or after January 1, 2011 due to the Affordable Care Act

MLN Matters® Number: MM7116
Related Change Request (CR) #: 7116
Related CR Release Date: October 15, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R786OTN
Implementation Date: January 3, 2011

Provider Types Affected
This article is for suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs) for the lump sum purchase for standard power wheelchairs.

What You Need to Know
This article is based on Change Request (CR) 7116 which informs Medicare DME MACs and RHHIs that Section 3136 of the Affordable Care Act eliminates the lump sum purchase payment for standard power wheelchairs, effective for items furnished on or after January 1, 2011. This elimination of the lump sum purchase payment applies to Health Care Common Procedural Coding System (HCPCS) codes K0813 through K0831 and code K0898 submitted with the NU or UE modifier for items furnished on or after January 1, 2011. (Note: This change will not apply to standard power wheelchairs furnished to beneficiaries in the nine competitive bidding areas (CBAs) of Round 1 Rebid of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program with dates of service January 1, 2011 thru December 31, 2013.) See the Background and Additional Information Sections of this article for further details regarding these changes.

Background
Power wheelchairs are included in the capped rental DME payment category and suppliers have been required to offer beneficiaries the option of receiving power wheelchairs on either a lump sum purchase basis or monthly rental basis. Claims for purchase of DME are submitted with the HCPCS modifier NU (purchase of new equipment) or UE (purchase of used equipment) while claims for rental of durable medical equipment are submitted with the HCPCS modifier RR. Beginning with items initially rented on or after January 1, 2006, suppliers have been required to transfer the equipment title for rented power wheelchairs to the beneficiary after the 13th month of continuous use.

Previous instructions on payment for power wheelchairs were released in Transmittal 918, Change Request (CR) 5010, dated April 28, 2006, and Transmittal 1037, CR 5255, dated August 25, 2006. MLN Matters® articles related to these transmittals are available at http://www.cms.gov/MLNMatersArticlesDOWNLOADS/MM5010.pdf

Additional Information
The official instruction, CR 7064, issued to your carriers, DME MACs, FIs and/or A/B MACs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2134CP.pdf on the CMS website. Attached to CR 7064, you may find the following documents to be helpful:

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

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

covered by this payer/contractor. You must send the claim to the correct payer/contractor.), RARC N538 (A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents), and assign Group code CO.

- All 72X claims from Method II facilities with condition code 74 will be treated as Method I claims as of January 1, 2011. Effective that same date, Medicare will no longer enter Method selection forms data into its systems.
- Services included in the existing composite rate continue to not be reported on the claim unless they are clinical lab services subject to the 50/50 rule. The only additional data that must be reported on or after January 1, 2011 are any oral and other equivalent forms of injectable drugs identified as outlier services. Oral and other equivalent forms of injectable drugs should be reported with the revenue code 0250. The drug NDC code must be reported with quantity field reflecting the smallest available unit.
- Payment for ESRD-related Aranesp and ESRD-related Epoetin Alfa (EPO) is included in the ESRD PPS for claims with dates of service on or after January 1, 2011.
- Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related drugs and biologicals are included in the ESRD PPS and must be billed by the renal dialysis facility.
Effective for items furnished on or after January 1, 2011, section 3136 of the Affordable Care Act eliminates the lump sum purchase payment for standard power wheelchairs. Suppliers must furnish these items on a monthly rental basis like other capped rental DME other than power wheelchairs. This elimination of lump sum purchase payment applies to standard power wheelchairs classified under the HCPCS codes for Group 1 power wheelchairs or Group 2 power wheelchairs without additional power options. The current HCPCS codes identifying standard power wheelchairs include codes K0813 thru K0831 and code K0898 for miscellaneous standard power wheelchairs. Claims with dates of service on or after January 1, 2011, for these HCPCS codes with modifier NU or UE will be denied since the statute prohibits payment on a purchase basis for these items. These codes are described in the following table.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0813</td>
<td>Power wheelchair, Group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0814</td>
<td>Power wheelchair, Group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0815</td>
<td>Power wheelchair, Group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0816</td>
<td>Power wheelchair, Group 1 standard, captains chair, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0820</td>
<td>Power wheelchair, Group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0821</td>
<td>Power wheelchair, Group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0822</td>
<td>Power wheelchair, Group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0823</td>
<td>Power wheelchair, Group 2 standard, captains chair, patient weight capacity up to and including 300 pounds.</td>
</tr>
<tr>
<td>K0824</td>
<td>Power wheelchair, Group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds.</td>
</tr>
<tr>
<td>K0825</td>
<td>Power wheelchair, Group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds.</td>
</tr>
<tr>
<td>K0826</td>
<td>Power wheelchair, Group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds.</td>
</tr>
<tr>
<td>K0827</td>
<td>Power wheelchair, Group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds.</td>
</tr>
<tr>
<td>K0828</td>
<td>Power wheelchair, Group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more.</td>
</tr>
<tr>
<td>K0829</td>
<td>Power wheelchair, Group 2 extra heavy duty, captains chair, patient weight capacity 601 pounds or more.</td>
</tr>
<tr>
<td>K0830</td>
<td>Power wheelchair, Group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity 126 to 300 pounds.</td>
</tr>
<tr>
<td>K0831</td>
<td>Power wheelchair, Group 2 standard, seat elevator, captains chair, patient weight capacity 126 to 300 pounds.</td>
</tr>
<tr>
<td>K0898</td>
<td>Power wheelchair, not otherwise classified.</td>
</tr>
</tbody>
</table>

Payment can continue to be made on a lump sum purchase basis or monthly rental basis for complex rehabilitative power wheelchairs. Complex rehabilitative power wheelchairs include Group 2 power wheelchairs with additional power options and Group 3 and higher power wheelchairs (HCPCS codes K0835 through K0843 and K0848 through K0864 as defined in Attachment B of CR 7116, which is available at http://www.cms.gov/Transmittals/downloads/R786OTN.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

In addition, this change will not apply to standard power wheelchairs furnished to beneficiaries in the nine competitive bidding areas (CBAs) of Round 1 Rebid of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program with dates of service January 1, 2011 thru December 31, 2013. The lump sum purchase payment method remains available for claims with dates of service January 1, 2011 thru December 31, 2013 for standard power wheelchairs furnished to beneficiaries residing in these nine CBAs.

Also, Section 3136 of Affordable Care Act changes the monthly fee schedule amounts for rental of standard and complex rehabilitative power wheelchairs furnished on or after January 1, 2011. Instructions for the revised fee schedule amounts are in the CY 2011 annual update for the DMEPOS fee schedule.

Additional Information The official instruction, CR 7116, issued to your DME MAC or RHHI regarding this change may be viewed at http://www.cms.gov/MLNMattersArticles/downloads/MM5255.pdf on the CMS website. If you have any questions, please contact your 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.
Robert D. Hoover, Jr., MD, MPH, FACP
Senior Medical Director
DME MAC Jurisdiction C

Therapeutic Shoes for Diabetics
Physician Documentation Requirements
for DME Reimbursement

Dear Physician,

Medicare covers therapeutic shoes and inserts for persons with diabetes. This statutory benefit is limited to one pair of shoes and up to 3 pairs of inserts or shoe modifications per calendar year. However, in order to qualify, the Medicare statute mandates specific coverage and documentation requirements that must be met.

The need for therapeutic shoes must be certified by a physician who is an M.D. or D.O. and who has the primary responsibility for treating the patient’s systemic diabetes. This physician must:

1. Document in the patient’s medical record that the patient has diabetes; and
2. Certify that the patient is being treated under a comprehensive plan of care for diabetes, and that the patient needs diabetic shoes; and
3. Document in the patient’s medical record the presence of one or more of the following conditions:
   a. Previous amputation of the other foot, or part of either foot, or
   b. History of previous foot ulceration of either foot, or
   c. History of pre-ulcerative calluses of either foot, or
   d. Peripheral neuropathy and evidence of callus formation of either foot, or
   e. Foot deformity of either foot, or
   f. Poor circulation (i.e., small or large vessel arterial insufficiency) in either foot.

A new certification statement, signed and dated by the treating physician, must be provided on a yearly basis in order to obtain a new pair of shoes or inserts.

It is important to note that even though you may complete and sign a form attesting that all of the coverage requirements have been met, there also must be documentation in your records to indicate that you are managing the patient’s diabetes and that one of the conditions listed in 3a – 3f is present. If requested by the supplier, you must provide copies of those records.

As with all items covered by Medicare, there must be a detailed written order for the items that are provided. The specifics of what is being provided may be entered by the supplier, but the physician must sign and date the order. Signature or date stamps are not acceptable. A new order is required yearly.

Although the requirements listed in 1-3 above must be documented by the M.D. or D.O. who has the primary responsibility for treating the patient’s diabetes, the order could be provided by that physician or by a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

CIGNA Government Services
Physicians can review the complete Local Coverage Determination and Policy Article titled Therapeutic Shoes for Persons with Diabetes on the CIGNA Government Services (CGS) website at http://cignagovernmentservices.com/jc/coverage/LCDinfo.html. It may also be viewed in the national Medicare Coverage Database at http://www.cms.hhs.gov.

Physicians are reminded that in order for these items to be reimbursed for your patients, the DME supplier will need to collect the medical documentation described above. Providing this documentation is in compliance with the HIPPA Privacy Rule. Also note that you may not charge the supplier or the beneficiary to provide this information. Please cooperate with the supplier so that they can provide the therapeutic shoes and inserts that are needed by your patient.

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

Medical Policy

**Treprostinil Inhalation Solution (Tyvaso®) – Coverage**

Effective for dates of service on or after January 1, 2011, least costly alternative payment policy will no longer be applied to the nebulizer used to administer treprostinil inhalation solution. This information will be added to the next revision of the Nebulizers policy.

For additional coverage, coding, and documentation requirements, suppliers should refer to the Nebulizer LCD and related Policy Article at http://www.cms.gov/mcd/search.asp?from2=search.asp&. Additional information specific to the coverage and coding of treprostinil was also published in August 2010 in an article titled Treprostinil Inhalation Solution (Tyvaso®) - Coverage and Coding.

**Oral Appliances for Obstructive Sleep Apnea – Finalized**

The draft Oral Appliances for Obstructive Sleep Apnea Local Coverage Determination (LCD) released for comment on September 18, 2008 has been finalized. It is effective for claims with dates of service on or after January 3, 2011.

Refer to the LCD and related Policy article for information about coverage, coding, and documentation.

**Draft Glucose Monitors Local Coverage Determination Withdrawn**

The DME MACs released a draft revision of the Glucose Monitors LCD for comment on September 23, 2010. The comment period ended November 8, 2010. Based upon the comments received this proposed revision has been withdrawn.
Local Coverage Determinations –
Elimination of Least Costly Alternative

CMS has instructed contractors that they may no longer make partial payment for claims based on a “least costly alternative” (LCA) determination. Therefore, for claims with dates of service on or after February 4, 2011, the following rules apply under this new guidance:

- If the local coverage determination (LCD) currently states that an item will always be paid based on the allowance for the least costly item (if the criteria for the less costly item are met), then under the new policy a claim for that item will always be denied as not medically necessary. (Type 1 LCA denial)
- If the LCD currently states that an item will be paid in full if specific additional coverage criteria are met but will be paid based on the allowance for the least costly item if the additional coverage criteria for the billed item are not met (and if the criteria for the less costly item are met), then under the new policy a claim for that item will be denied as not medically necessary if all of the additional coverage criteria for that item are not met. (Type 2 LCA denial)

The claim will be paid in full if the additional coverage criteria are met.

A KX modifier is required to attest to the additional coverage criteria being met. Claims without a KX modifier (and with a GA, GY, or GZ modifier) will be denied.

If a base code for an item of durable medical equipment, prosthesis, or orthosis is denied as not medically necessary, all related accessories, supplies, additions, and drugs will be denied as not medically necessary.

Least costly alternative statements are found in the following LCDs:

Note: The information may not be all-inclusive; refer to each LCD for details.

Ankle-Foot/Knee-Ankle-Foot Orthoses

Canes and Crutches
- Underarm articulating spring assisted crutch (E0117) (Type 1)

Cervical Traction Devices
- Cervical traction by headboard attachment (E0840) (Type 1)
- Cervical traction by freestanding frame (E0850) (Type 1)
- Cervical traction, free standing stand/frame, traction force to other than mandible (E0849) (Type 2)
- Cervical traction, not requiring stand/frame (E0855) (Type 2)

Commodities
- Commode – extra wide/ heavy duty (E0168) (Type 2)

Enteral Nutrition
- Special enteral nutrients (B4149, B4153, B4157, B4161, B4162) (Type 2)
- Pump supply kit (B4035) (Type 2)

External Breast Prostheses
- Breast prostheses, silicone or equal, with integral adhesive (L8031) (Type 1)
- Custom fabricated breast prosthesis (L8035) (Type 1)

External Infusion Pumps
- Infusion pump used with subcutaneous immune globulin (E0781, E0791) (Type 1)

Glucose Monitors
- Glucose monitors with special features (E2100, E2101) (Type 2)
- Laser lancing device and lens shield cartridge (E0620, A4257) (Type 1)

Hospital Beds
- Total electric hospital bed (E0265, E0266, E0296, E0297) (Type 1)
- Other hospital beds (E0255-E0261, E0292-E0295, E0301-E0304, E0329) (Type 2)

Knee Orthoses
- Knee orthosis with inflatable bladder (L1847) (Type 1)
- Custom fabricated orthoses (L1834, L1840, L1844, L1846, L1860) (Type 2)

Manual Wheelchairs
- Manual wheelchairs (K0002 – K0007) (Type 2)

Nebulizer Equipment and Related Drugs
- Small volume ultrasonic nebulizer (E0574) (Type 1)
- Battery-powered nebulizer (E0571) (Type 1) (Exception: Coding for these items is being changed.)
- Controlled dose delivery system (K0730) (Type 2)

Patient Lifts
- Patient support system with integrated lift (E0636) (Type 2)
- Multi-positional patient transfer systems (E1035, E1036) (Type 2)

Pneumatic Compression Devices
- Segmented device with manual chamber control (E0652) (Type 2)

Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea
- Bi-level without backup (E0470) (Type 2)
- Bi-level with backup used for OSA (E0471) (Type 1)

Power Mobility Devices
- Power operated vehicles – Group 1 (K0801, K0802) (Type 2)
- Power operated vehicles – Group 2 (K0806 – K0808) (Type 1) (Exception: Will be denied as statutorily non-covered.)
- Power wheelchairs – Group 2 with seat elevator and Group 4 (K0830, K0831, K0868 – K0886) (Type 1) (Exception: Will be denied as statutorily non-covered.)
- Power wheelchairs – Groups 1, 2, 3, and 5 (K0813 – K0829, K0835 – K0864, K0890, K0891) (Type 2)

Respiratory Assist Devices
- Bi-level with backup rate (E0471) (Type 2)
For items that were previously paid based on an LCA determination, suppliers can receive partial payment at the time of initial determination if they elect to bill using one of the upgrade modifiers, GK or GL. Refer to the related article titled Use of Upgrade Modifiers.

Further instructions will be forthcoming concerning the options that a supplier has if a claim is submitted without upgrade modifiers and is denied as not medically necessary and the supplier subsequently decides that it would like to utilize the upgrade modifiers.

A webinar to enhance your understanding will be coming soon.

**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. When suppliers know that an item will not be paid in full because it does not meet the coverage criteria stated in the LCD, the supplier can still obtain partial payment at the time of initial determination if the claim is billed using one of the upgrade modifiers, GK or GL. The descriptions of the modifiers are:

- **GK** - Reasonable and necessary item/service associated with a GA or GZ modifier
- **GL** - Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

If a supplier wants to collect from the beneficiary for the upgraded item provided, a properly completed ABN must be obtained. If an ABN is obtained, on one claim line the supplier bills with a GA modifier the HCPCS code that describes the item that was *provided*. On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is *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 co-insurance that relate to the allowed charge for the GK claim line. *The supplier may charge their "usual and customary" fee for the upgraded item that is provided."

If a supplier wants to provide the upgraded item without any additional charge to the beneficiary, then no ABN is obtained. If it is the supplier's decision to provide the upgraded item at no additional charge to the beneficiary or if physician ordered the upgraded item and the supplier decides to provide it at no additional charge to the beneficiary, the supplier bills with a GL modifier the HCPCS code that describes the item that is *covered* based on the LCD. In this situation, the supplier does not bill the HCPCS code that describes the item that was *provided.*

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**DME MAC Jurisdiction C INSIDER**

**Seat Lift Mechanisms**
- Seat lift mechanism incorporated into chair (E0627) (Type 1)
  (Exception: E0627 will be paid in full.)

**Surgical Dressings**
- Water or saline impregnated gauze (A6228-A6230) (Type 1)

**Therapeutic Shoes for Persons with Diabetes**
- Custom fabricated shoes (A5501) (Type 2)

**Tracheostomy Supplies**
- Tracheostomy starter kit (A4625) (Type 2)

**Urological Supplies**
- Specialty indwelling catheter (A4340) (Type 2)
- All silicone catheter (A4344, A4312, or A4315) (Type 2)
- Three way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) (Type 2)
- Drainage bags containing gel matrix or other material (Type 1)
- Coude (curved) tip catheter (A4352) (Type 2)
- Specialty type male external catheters (A4326) (Type 2)
- Catheter/tube anchoring device (A5200) (Type 2)

**Walkers**
- Heavy duty walker (E0148, E0149) (Type 2)
- Heavy duty, multiple braking system, variable wheel resistance walker (E0147) (Type 2)
- Walker with an enclosed frame (E0144) (Type 1)
- Walker with trunk support (E0140) (Type 2)

**Wheelchair Options and Accessories**
- Dual mode battery charger (E2367) (Type 1)

**Wheelchair Seating**
- General use seat and back cushion (when used with power WC with sling/solid seat) (Type 2)
- Skin protection seat cushion, positioning seat cushion, or combination skin protection and positioning seat cushion (E2603-E2608, E2613-E2616, E2620, E2621, E2622-E2625) (Type 2)
- Positioning back cushion (E2613-E2616, E2620, E2621) (Type 2)
- Custom fabricated cushion (E2609, E2617) (Type 2)

Revisions of these LCDs incorporating these changes are being published – refer to the individual policies for details.

For capped rental DME items, elimination of LCA determinations will apply only to claims in which the date of service (DOS) for the initial rental month is on or after February 4, 2011. If an LCA determination is made on an item with an initial rental month DOS prior to February 4, 2011, subsequent claims for that item will continue to be adjudicated using the LCA determination for the duration of that rental period.

If an item is denied in full due to elimination of LCA, partial payment based on LCA will not be possible through the appeals process.
If the request for the upgraded item is from the beneficiary and the supplier decides to provide it at no additional charge, no ABN is obtained. On one claim line the supplier bills with a GZ modifier the HCPCS code that describes the item that was provided. On the next claim line, the supplier bills with a GK modifier the HCPCS code that describes the item that is covered based on the LCD. (Note: The codes must be billed in this specific order on the claim.)

<table>
<thead>
<tr>
<th>DME Upgrades - ABN and Claims Modifiers</th>
<th>ABN Required</th>
<th>Required Modifier(s)</th>
<th>DMAC Payment</th>
<th>Beneficiary Pays for Upgrade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physician orders upgrade:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Supplier provides upgrade free of charge to beneficiary</td>
<td>No</td>
<td>GL</td>
<td>R&amp;N item only (GL line)</td>
<td>No</td>
</tr>
<tr>
<td>b. Supplier bills beneficiary for upgrade</td>
<td>Yes</td>
<td>GA/GK</td>
<td>R&amp;N item only (GK line)</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Patient requests upgrade:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Supplier provides upgrade free of charge to beneficiary</td>
<td>No</td>
<td>GL</td>
<td>R&amp;N item only (GL line)</td>
<td>No</td>
</tr>
<tr>
<td>b. Supplier bills beneficiary for upgrade</td>
<td>Yes</td>
<td>GA/GK</td>
<td>R&amp;N item only (GK line)</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Supplier provides upgrade for supplier convenience:</td>
<td>No</td>
<td>GL</td>
<td>R&amp;N item only (GK line)</td>
<td>No</td>
</tr>
</tbody>
</table>

Table Footnotes: GK or GL is added to HCPCS code for item that meets Medicare coverage requirements. When GK is used, GA or GZ is added to HCPCS code for item that is provided. R&N = Reasonable and necessary

Suppliers are reminded that if there is a requirement in a specific policy to use a KX modifier to indicate that an item meets coverage criteria, then it is used in addition to the GK or GL modifier. Codes with a GK or GL modifier will continue through the usual claims processing. Other edits may cause the GK/GL claim line to be denied. However, if no other edits are involved, payment will be made based on the fee schedule for the code with the GK or GL modifier.

Resubmitting Claims with Upgrade Modifiers

For certain items that were previously subject to least costly alternative (LCA) payment policy, suppliers will now receive a not reasonable and necessary denial. For these items only, suppliers have the option of resubmitting the claim using the upgrade modifiers and the code for the covered medically necessary item rather than exercising the option of Appeals. For example, a supplier submits a claim after February 4, 2011 for code E0265 (fully electric hospital bed) and the claim is denied as not reasonable and necessary. That claim may be resubmitted with code E0265 and the appropriate modifiers on Line 1 and code E0260 and the appropriate modifiers on Line 2. Resubmitting the claim in this fashion will not result in a conflict with the original code E0265 claim and subsequent duplicate claim denial.

These resubmission instructions apply only to items previously subject to LCA payment policy that now receive not reasonable and necessary denials. Other items receiving reasonable and necessary denials must follow the usual redeterminations process.


Home Dialysis and Epoetin - Medical Policies Retired

Effective for claims with dates of service on or after January 1, 2011, Method II home dialysis is no longer an option. All claims for home dialysis and related epoetin use will be submitted to the Medicare Part A/B contractors. Therefore, the DME MAC Local Coverage Determinations and Policy Articles for Home Dialysis Supplies and Equipment and for Epoetin will be retired with an ending date of December 31, 2010.

Specialty Enteral Formulas

Effective with dates of service on or after February 4, 2011 claims submitted to the DME MAC’s for HCPCS Codes B4149, B4153-B4157, B4161, and B4162 will no longer be subjected to least costly alternative payment policy and downcoded to B4150 or B4152 (semi-synthetic intact protein/protein isolate formulas). For dates of service on or after February 4, 2011, claims for HCPCS Codes B4149, B4153-B4157, B4161, and B4162 will be denied as not reasonable and necessary unless the coverage criteria for specialty nutrients is met. Suppliers also have the option of using the upgrade modifiers as noted in the recent DME MAC publication on Use of Upgrade Modifiers.

Refer to LCD for Enteral Nutrition for additional coverage, coding and documentation requirements.

LCD and Policy Article Revisions - Summary for December 2010

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

Ankle-Foot / Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 02/04/2011

Indications & Limitations of Coverage:

- **Added**: Statement from policy article regarding routine replacement of components.
External Breast Prosthesis

LCD

Revision Effective Date: 02/04/2011

Indications & Limitations of Coverage and/or Medical Necessity:
- **Added:** 198.81, 457.0, V10.3 as covered indications
- **Deleted:** Least costly alternative for multiple codes

Covered ICD-9 Codes:
- **Added:** 198.81, 457.0, V10.3

Policy Article

Revision Effective Date: 02/04/2011

Non-Medical Necessity Coverage & Payment Rules:
- **Added:** Preamble language
- **Revised:** Clarified non-coverage statements for L4392, L4394, L4396 and L4398.

Coding Guidelines:
- **Added:** Definition of L4631
- **Revised:** Clarified proper coding instructions based on brace use.

Canes and Crutches

LCD

Revision Effective Date: 02/04/2011

Indications & Limitations of Coverage:
- **Revised:** Preamble language
- **Deleted:** Least costly alternative language for code E0117

Cervical Traction Devices

LCD

Revision Effective Date: 02/04/2011

Indications & Limitations of Coverage:
- **Deleted:** Least costly alternative language for multiple codes

Commodes

LCD

Revision Effective Date: 02/04/2011

Indications & Limitations of Coverage:
- **Deleted:** Least costly alternative language for code E0168

Enteral Nutrition

LCD

Revision Effective Date: 02/04/2011

Indications & Limitations of Coverage:
- **Deleted:** Least costly alternative language for special enteral formulas and supply kits

Glucose Monitors

LCD

Revision Effective Date: 02/04/2011

Indications & Limitations of Coverage:
- **Revised:** Preamble language
- **Deleted:** Least costly alternative language for codes E2100 and E2101
- **Deleted:** Least costly alternative language for codes E0620 and A4257

Note: This is NOT a release of the draft Glucose Monitors policy that was recently out for comment. This is a revision to the existing policy.
Hospital Beds

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

**Knee Orthosis**

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for multiple HCPCS codes

**HCPCS Codes & Modifiers:**
- **Added:** Code L4002
- **Revised:** GA modifier

**ICD-9 Codes that Support Medical Necessity:**
- **Added:** ICD-9 code 844.8 for codes L1830, L1832, L1834, and L1843-L1846

**Policy Article**

**Revision Effective Date:** 02/04/2011

**Non-Medical Necessity Coverage & Payment Rules:**
- **Added:** Preamble language
- **Added:** Noncoverage statement for nebulizer used to administer aztreonam lysine and related accessories

**Coding Guidelines:**
- **Added:** Coding information for nebulizer used to administer aztreonam lysine inhalation solution and related accessories.
- **Added:** Coding verification review for E0574 ultrasonic nebulizers (Effective for DOS on or after 4/1/2011)
- **Added:** Code E0571 invalid for DME MAC submission
- **Revised:** Definition of E0570 to include battery-powered aerosol compressors

**Manual Wheelchairs**

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for K0002 – K0007

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

**Nebulizers**

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Added:** Coverage for treprostinil inhalation solution
- **Revised:** Coverage of E0574, E0575
- **Deleted:** References to code E0571

**HCPCS CODES AND MODIFIERS (Effective 1/1/2011):**
- **Added:** J7686
- **Revised:** J7013
- **Revised:** GA modifier
- **Deleted:** E0571

**ICD-9 Codes that Support Medical Necessity:**
- **Added:** A7013, A7014, A7016, E0574, J7686 to pulmonary hypertension ICD-9 code
- **Deleted:** Code E0574 from COPD code set
- **Deleted:** Code E0571

**Patient Lifts**

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Removed:** Least costly alternative language for codes E0636, E0135, and E0136.

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

**Pneumatic Compression Devices**

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least Costly Alternative for HCPCPS code E0652

**Positive Airway Pressure Devices**

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for codes E0470 and E0471

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

**Documentation Requirements:**
- **Revised:** Requirements for documenting ineffective therapy on E0601
Power Mobility Devices

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Revised:** Denial statements for custom fabricated shoes

**Documentation Requirements:**
- **Added:** Statement about timing of detailed written order (effective 1/1/2011).
- **Added:** Clarification about documentation that must be in the certifying physician’s records.
- **Added:** Documentation required at the time of selecting the shoes/inserts (effective 7/1/2010).
- **Added:** Documentation required at the time of delivery (effective 7/1/2010).

**Urological Supplies**

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for multiple codes
- **Revised:** Coverage of A4336
- **Added:** A5105 to list of codes used with A5131

**ICD-9 Codes that Support Medical Necessity:**
- **Added:** 625.6 for HCPCS A4336

**Policy Article**

**Revision Effective Date:** 02/04/2011

**Non-Medical Necessity Coverage & Payment Rules:**
- **Added:** Preamble language
- **Added:** Clarification about documentation that must be in the certifying physician’s records.

**Coding Guidelines:**
- **Revised:** A4253 definition
- **Revised:** Bundling table instructions
- **Deleted:** A4353 from table

Walkers

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for heavy-duty walkers, E0147 walkers, and walkers with an enclosed frame or trunk support.

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

Therapeutic Shoes

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least Costly Alternative for A4625

Respiratory Assist Devices

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Revised:** Coverage criteria relating to patient weight for POVs and PWCs

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

Seal Lift Mechanisms

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for E0471

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

Surgical Dressings

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for E0627

**HCPCS Codes (effective 1/01/2011):**
- **Revised:** A6011, A6248, A6260-A6262

Tracheostomy Supplies

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for HCPCS codes A6228-A6230

**HCPCS Codes (effective 1/01/2011):**
- **Revised:** A6011, A6248, A6260-A6262

Wheelchair Options and Accessories

**LCD**

**Revision Effective Date:** 02/04/2011

**Indications & Limitations of Coverage:**
- **Deleted:** Least costly alternative language for dual mode battery chargers

**HCPCS Codes & Modifiers:**
- **Revised:** GA modifier

Policy Article

**Revision Effective Date:** 01/01/2011
Non-Medical Necessity Coverage & Payment Rules:

- **Added**: Introductory statement concerning content of Policy Articles.

Coding Guidelines:

- **Revised**: Instructions for use of the RT and LT modifiers when unit of service is “pair”.
- **Clarified**: Billing instructions for expandable controllers (E2377, E2376), electronic harnesses (E2313), and special features of joysticks.
- **Added**: Statement that E1028 is not separately billable with a wheelchair tray and added E0950 to bundling table

**Wheelchair Seating**

**LCD**

**Revision Effective Date**: 02/04/2011

Indications & Limitations of Coverage:

- **Revised**: Denial statements for general use cushions used with power wheelchairs with sling/solid seats/backs, for skin protection, positioning and combination seat cushions, for positioning back cushions, and for custom fabricated cushions.

**HCPCS Codes & Modifiers** (effective 01/01/2011):

- **Added**: E2622 - E2625
- **Revised**: GA
- **Deleted**: K0734 – K0737

**ICD-9 Codes that Support Medical Necessity**:

- **Replaced**: K0734-K0737 with E2622-E2625

**Documentation Requirements**:

- **Replaced**: K0734-K0737 with E2622-E2625

**Policy Article**

**Revision Effective Date**: 01/01/2011

Non-Medical Necessity Coverage & Payment Rules:

- **Added**: Introductory statement concerning content of Policy Articles.

Coding Guidelines:

- **Replaced**: K0734-K0737 with E2622-E2625

A webinar to enhance your understanding will be coming soon.

**Lessons Learned:**

**Widespread Probe Reviews of J7507 & J7517**

CIGNA Government Services recently conducted widespread post payment probe reviews on 200 randomly selected HCPCS code J7507 and J7517 claims. Our findings are summarized below.

A large number of suppliers failed to respond to our request for records.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516(f)) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC.

**Delivery documentation errors included:**

- No delivery documentation provided;
- Name of the drug was not provided in the delivery documentation;
- No signature on delivery slip or tracking information to confirm delivery;
- Illegible delivery documentation;
- Date of service billed did not match the date of delivery/shipping date;
- Beneficiary’s name was not included on the delivery documentation;
- Date of delivery was not listed on the delivery slip; and
- Delivery documentation was not for the drug under review.

Proof of delivery is another supplier standard as noted in 42 CFR §424.57(12). Chapter Three of the DME MAC Jurisdiction C Supplier Manual contains detailed instructions on the information suppliers should maintain in order to verify proof of delivery.

Reviewers noted that many of the delivery documents included a prescription (RX) number instead of listing the name of the drug being supplied. Therefore the reviewer was unable to verify that the supplier provided the drug that was billed and that the item was correctly coded.

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.

**The identified detailed written order errors were:**

- No written order provided;
- Illegible detailed written order (blackened and/or blurred);
- Detailed written order was for the wrong drug;
- Physician did not personally date his/her signature;
- Detailed written order was signed by R.N. without being co-signed by the treating physician; and
- Items delivered prior to obtaining a detailed written order and no documentation of a preliminary dispensing order provided.

Please remember that it is the supplier’s responsibility to assure that all Medicare documentation requirements are met. Chapter Three of the DME MAC Jurisdiction C Supplier Manual also includes a section on physician orders where regulations for both preliminary dispensing orders and detailed written orders are discussed.

Not only must suppliers assure that documentation requirements are met but also that the copies made available upon request are legible copies. If in doubt as to whether a document will be legible if faxed, we suggest that the supplier fax a test copy to themselves. In situations where the faxed document is too dark to read,
Identified problems with documentation in the patient’s medical record were:

- No medical records provided;
- Missing/illegible signature on records; and
- Records provided did not document a transplant.

Medicare regulations at 42 C.F.R. §410.30 instruct that payment for prescription drugs used in immunosuppressive therapy is furnished if Medicare paid for the organ transplant. Further instructions are contained in the Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual (CMS Internet-Only Manual Publication 100-4) Chapter 17, §80.3 which states:

If a supplier has not determined (or does not have documentation on file to support a determination) that either the beneficiary did not receive an organ transplant or that the beneficiary was not enrolled in Medicare Part A as of the date of the transplant, then the supplier may not, with respect to furnishing an immunosuppressive drug: 1) bill Medicare, 2) bill or collect any amount from the beneficiary, or 3) issue an Advance Beneficiary Notice (ABN) to the beneficiary.

While documentation in the patient’s medical record does not need to be routinely sent to a Medicare contractor, it must be available upon request. If the information is not received when requested or the information does not adequately support the medical necessity for the item, payment may be denied.

Some suppliers are still using the Immunosuppressive Drug DME MAC Information Form (DIF).

The Immunosuppressive Drug DIF is a retired CMS form and completion of this form is no longer a documentation requirement. Furthermore, use of this form will not be recognized by a Medicare contractor in support of medical need or any other coverage criterion.

The widespread probe reviews of J7507 and J7517 showed that suppliers are not following published Medicare guidelines and policies in submitting claims for these services. The combined calculated error rate of the two probe reviews (determined by dividing the dollar amount of services paid in error by the dollar amount of services medically reviewed) was 87%.

Please remember, in the event of either a prepayment or post payment claim review that Medicare can only pay for services that are actually documented. Suppliers are encouraged to follow all Medicare documentation regulations in order to avoid claim denials and overpayment assessments.
Key Points for Medicare Billers

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

Additional Information

If you have questions, please contact your Medicare MAC and/or FI/carrier at their toll-free number which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website. The official instruction (CR 7041) issued to your Medicare MAC and/or FI/carrier is available at http://www.cms.gov/Transmittals/downloads/R763OTN.pdf on the CMS website.

Instructions for PLB Code Reporting on Remittance Advice, a Crosswalk Between the HIGLAS PLB Codes and ASC X12 Transaction 835 PLB Codes, and RAC Recoupment Reporting on Remittance Advice for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Claims

MLN Matters® Number: MM7068 Revised
Related Change Request (CR) #: 7068
Related CR Release Date: November 12, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R812OTN
Implementation Date: April 4, 2011; July 5, 2011 for Institutional providers and DME Suppliers

Note: This article was revised on December 8, 2010, to add a reference to MLN Matters® article MM6870, which is available at http://www.cms.gov/MLNMattersArticles/downloads/MM6870.pdf, which instructs FIs and A/B MACs to provide enough detail in the RA to enable physicians, providers and suppliers to reconcile their claims.

Provider Types Affected

All physicians, providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for Medicare beneficiaries are affected.

Provider Action Needed

Change Request (CR) 7068 provides instructions to Medicare Carriers, MACs, FIs, and RHHIs about using and reporting PLB codes on the Remittance Advice (RA). It also includes instruction for DME MACs for reporting RAC recoupment when there is a time difference between the creation of the Accounts Receivable and actual recoupment of money.

The attachment in CR 7068 provides a list of PLB codes to be reported on the 835 as well as the paper remittance advice and a crosswalk between the HIGLAS PLB codes and the ASC X12 Transaction 835 PLB codes to ensure that PLB code reporting on the RA is consistent and uniform across the board.

Background

In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national Recovery Audit Contractors (RAC) program to be in place by January 1, 2010. The goal of the recovery audit program is to identify improper payments made on claims of health care services provided to Medicare beneficiaries. The RACs review claims on a post-payment basis, and can go back 3 years from the date the claim was paid. To minimize provider burden, the maximum look back date is October 1, 2007.
Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Publication L.108-173) which amended Title XVIII of the Social Security Act (the Act) has added a new paragraph (f) to §1893 of the Act, the Medicare Integrity Program. The statute requires Medicare to change how certain overpayments are recouped. These new changes to recoupment and interest are tied to the Medicare fee-for-service claims appeal process and structure.

Recoupment under the provisions of Section 935 of the MMA can begin no earlier than the 41st day (see CR6183 – Transmittal 141, issued September 12, 2008), and can happen only when a valid request for a redetermination has not been received within that period of time.

Under the scenario just described, the RA has to report the actual recoupment in two steps:

- **Step I:** Reversal and Correction to report the new payment and negate the original payment (actual recoupment of money does not happen here)
- **Step II:** Report the actual recoupment.

In a previous CR (Transmittal 659, CR6870), Medicare Carriers, FIs and A/B MACs were instructed to provide enough detail in the RA to enable providers to track and update their records to reconcile Medicare payments. The Front Matter 1.10.2.17 – Claim Overpayment Recovery – in ASC X12N/005010X221 provides a step-by-step process, regarding how to report in the RA when funds are not recouped immediately, and a manual reporting (demand letter) is also done. CR7068 instructs DME MACs how to report on the RA when an overpayment is identified and also when Medicare actually recoups the overpayment in a future RA.

**RAC Recoupment Reporting – DME Claims Only**

- **Step I: Claim Level**
  - The original claim payment is taken back and the new payment is established (Reversal and Correction).
  - Provider Level:
    - PLB03-1 – PLB reason code FB (Forward Balance)
    - PLB 03-2 shows the detail:
      - PLB-03-2
        - 1-2: 00
        - 3-19: Adjustment CCN#
        - 20-30: HIC#
    - PLB04 shows the adjustment amount to offset the net adjustment amount shown at the service level. If the service level net adjustment amount is positive, the PLB amount would be negative and vice versa.

- **Step II: Claim Level**
  - No additional information at this step
  - Provider Level:
    - PLB03-1 – PLB reason code WO (Overpayment Recovery)
    - PLB 03-2 shows the detail:
      - PLB-03-2
        - 1-2: 00

**Note:** CR 7068 instructions, regarding recoupment, apply to both 004010A1 and 005010 versions of ASC X12 Transaction 835 and Standard Paper Remittance (SPR). In some very special cases the HIC # may have to be truncated to be compliant with the 004010A1 Implementation Guide

**PLB Code Reporting**

The RA reports payments and adjustments to payments at 3 levels: a) service, b) claim, and c) provider.

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- Go to: [http://www.cignagovernmentservices.com/](http://www.cignagovernmentservices.com/)
- Then click on “Join ListServ.”
The adjustments at the service and the claim level are reported using 3 sets of codes:

- Group Codes,
- Claim Adjustment Reason Codes (CARCs), and
- Remittance Advice Remark Codes (RARCs).

Provider level adjustments are reported using the PLB codes. The PLB code list is an internal code list that can be changed only when there is a change in the version.

In Version 004010A1, the following PLB codes are available for use: 50, 51, 72, 90, AM, AP, B2, B3, BD, BN, C5, CR, CS, CT, CV, CW, DM, E3, FB, FC, GO, IP, IR, IS, J1, L3, L6, LE, LS, OA, OB, PI, PL, RA, RE, SL, TL, WO, WU, AND ZZ. In version 005010, two new codes – AH and HM – have been added, and code ZZ has been deleted. The other change in Version 005010 is the way situational field PLB03-2 for reference identification is used.

<table>
<thead>
<tr>
<th>Field</th>
<th>Version 00401A1</th>
<th>Version 005010</th>
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<tr>
<td>PLB03-1</td>
<td></td>
<td>AH – additional code</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HM – additional code</td>
</tr>
<tr>
<td></td>
<td>Max: 30</td>
<td>ZZ – deleted code</td>
</tr>
<tr>
<td>PLB03-2</td>
<td>Position 1-2:</td>
<td>Medicare intermediaries</td>
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<tr>
<td></td>
<td>Position 3-19:</td>
<td>Financial control number</td>
</tr>
<tr>
<td></td>
<td>Max: 50</td>
<td>Required when a control, account or tracking number applies to this adjustment as reported in field PLB03-1. No Medicare specific codes.</td>
</tr>
</tbody>
</table>

HIGLAS uses additional PLB codes from the X12 Standard that are not in the Implementation Guide (IG) or Technical Report (TR) 3. Medicare must use only those codes that are included in the IG/ TR3 to report on the 835.

**HIGLAS PLB Codes and ASC X12 Crosswalk**

Currently CMS is transitioning to HIGLAS, and some contractors are still not under HIGLAS. CR 7068 applies to both HIGLAS and Non-HIGLAS contractors with the goal of uniform and consistent reporting on the 835 across the board. Secondly, CMS is also in the process of implementing version 005010/005010A1. Attachment – 835 PLB Code Mapping is applicable to Version 00401A1 as well as 005010A1. The PLB codes to report on the 835 and HIGLAS and HIPAA PLB Crosswalk may be found in the attachment in CR 7068.

**Additional Information**


**Implementation of Errata Version 5010 of Health Insurance Portability and Accountability Act (HIPAA) Transactions, and Updates in 837I, 837P, and 835 Flat Files**

MLN Matters® Number: MM7202
Related Change Request (CR) #: 7202
Related CR Release Date: November 10, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2090CP
Implementation Date: April 4, 2011

**Provider Types Affected**

This article is for physicians, providers and suppliers who bill Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment (DME) MACs, and Regional Home Health Intermediaries (RHHI)), for services provided to Medicare beneficiaries.

**Provider Action Needed**

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7202 to alert and update providers about the Administrative Simplification provisions of HIPAA Regulations that the Secretary of the Department of Health and Human Services (DHHS) is required to adopt regarding standard electronic transactions and code sets. Currently, CMS is in the process of implementing an ERRATA version of 5010 of the HIPAA transactions as well as the updates to the 837I, 837P and 835 flat files. **Be sure that you will be compliant with this next HIPAA standard by January 1, 2012.**

**Background**

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

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

To review the explanation of these levels you may go to an earlier MLN Matters® article, MM6975 on the Additional Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 5010 for Transaction 835 - Health Care

**Key Points of CR7202**

CMS is working with your Medicare contractors to implement the new HIPAA standard (version 5010) correctly and:

- CMS expects that external testing will start on January 2011, but no sender/receiver will be migrated to 5010A1 production before April 2011;
- During the transition period January 2011 - March, 2011, Medicare contractors will be ready to receive/send transactions in version 4010A1 as well as test in version 5010. From April 2011 to December 2011, contractors will be ready to receive/send transactions in version 4010A1 as well as test and receive/send all transactions in version 5010 or the appropriate errata versions; and
- All Medicare claims processing systems will use appropriate X12 based Flat File layouts for transactions 837I, 837P, and 835, as attached to CR7202. (To review the file descriptions, go to [http://www.cms.gov/Transmittals/downloads/R2090CP.pdf](http://www.cms.gov/Transmittals/downloads/R2090CP.pdf) on the CMS website.)
- Over the past year, there has been discussion about modifications needed to implement 5010 correctly. As a result, X12N released the ERRATA modifications, and they were adopted by DHHS. CMS will implement the changes that impact Medicare and update the relevant flat files even if specific modifications do not impact Medicare.
- The ERRATA are basically modifications to some of the TR3s. For Medicare the following TR3 name changes will be required per:
  - 005010X279A1 270/271 Health Care Eligibility Benefit Inquiry and Response (A separate CR will be issued for the 270/271);
  - 005010X221A1 835 Health Care Claim Payment/Advice;
  - 005010X222A1 837 Health Care Claim: Professional;
  - 005010X223A2 837 Health Care Claim: Institutional; and
  - 005010X231A1 999 Implementation Acknowledgment for Health Care Insurance.

**Additional Information**


If you have any questions, please contact your carrier, A/B MAC, or RHHI 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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### Medicare Fee-For-Service Emergency Policies and Procedures:

**Questions and Answers (Qs & As) for All Types of Emergencies and Disasters — Rescission of CRs 5099, 6146, 6164, 6174, 6209, 6256, 6280, 6284, and 6378**

**MLN Matters® Number:** MM6837  
**Related Change Request (CR) #:** 6837  
**Related CR Release Date:** September 21, 2010  
**Effective Date:** November 22, 2010  
**Related CR Transmittal #:** R772OTN  
**Implementation Date:** November 22, 2010

**Provider Types Affected**

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

**Provider Action Needed**

This article is informational only and advises providers on where to find information regarding Medicare policies related to emergency guidance for the duration of the emergency, such as the H1N1 pandemic.

**Background**

As part of its preparedness efforts for an influenza pandemic, the Centers for Medicare & Medicaid Services (CMS) developed certain emergency guidance and procedures that may be implemented for the Medicare fee-for-service (FFS) program in the event of a pandemic or disaster.

Additional pandemic-specific preparedness guidance and procedures were issued in prior Change Requests (CRs). CR 6837 rescinds the CRs implementing selected influenza pandemic-specific guidance and procedures. Specifically, CR 6837 rescinds CRs 5099, 6146, 6164, 6174, 6209, 6256, 6280, 6284, and 6378. The guidance and procedures (in the form of Questions & Answers (Qs & As)) previously implemented by the aforementioned CRs will, instead, be made available on the CMS “Emergency” website at [http://www.cms.gov/Emergency/](http://www.cms.gov/Emergency/) and entitled:

- “Emergency Qs & As – no 1135 waivers required,” and
- “Emergency Qs & As – applicable only when an applicable 1135 waiver has been granted.”

**Additional Information**

The official instruction, CR 6837, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at
Implementation of Section 2902 of the Affordable Care Act for Indian Health Service (IHS) Part B Services and All Inclusive Rate (AIR) Billing for Return Visits

MLN Matters® Number: MM6908  
Related Change Request (CR) #: 6908  
Related CR Release Date: October 28, 2010  
Effective Date: January 1, 2010  
Related CR Transmittal #: R2075CP  
Implementation Date: January 28, 2011

Provider Types Affected

This article is for IHS providers receiving payment under the AIR payment methodology for Part B hospital outpatient services.

Provider Action Needed

This article is based on Change Request (CR) 6908 which clarifies billing for return visits to IHS providers under the AIR payment methodology. See the Background and Additional Information Sections of this article for further details regarding this clarification.

CR 6908 also implements Section 2902 of The Affordable Care Act, which extends indefinitely Section 630 of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), retroactive to January 1, 2010. MLN Matters® article SE0930 contains more details on this extension of Section 630 of the MMA. The article is available at http://www.cms.gov/MLNMattersArticles/downloads/SE0930.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Background

CR 6908 updates the Medicare Claims Processing Manual (Chapter 19, Section100.5.1) to clarify that, while at least one face-to-face encounter with a physician (or non-physician practitioner) is required for an initial visit to count as a billable AIR encounter, the same is not always true of return visits to obtain follow-up care ordered by the physician (or non-physician practitioner) during the initial visit.

CR 6908 further states that it is appropriate for a return encounter to be billed on the date the procedure or test is furnished and for the provider to receive an additional AIR payment (even if the beneficiary did not interact with a physician or non-physician practitioner during the return visit) if:

- A physician (or non-physician practitioner) orders a specific procedure or test which cannot be furnished until a later date after the date of the initial visit with the physician (or non-physician practitioner); and
- The procedures or tests are medically necessary.

Examples of medically necessary reasons for return visits would include a requirement that:

1. The beneficiary fast for 12 hours prior to an ordered test; or
2. A chest X-ray be provided two weeks following the initiation of antibiotic treatment for pneumonia.

Also, a return visit would be considered medically necessary if a beneficiary must return on another day for a medically necessary test ordered during an initial visit because the test cannot be performed on the day it is ordered due to provider or patient constraints that cannot be overcome.

Additional Information

The official instruction, CR 6908, issued to your carrier, DME MAC and/or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2075CP.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.

Provider Education for Handling National Provider Identifier (NPI) Issues Related to Deceased Providers Who Had an NPI

MLN Matters® Number: MM6984  
Related Change Request (CR) #: 6984  
Related CR Release Date: November 5, 2010  
Effective Date: Claims processed on or after April 4, 2011  
Related CR Transmittal #: R799OTN  
Implementation Date: April 4, 2011

Provider Types Affected

This article is relevant for claims of physicians, non-physician practitioners, and other providers/suppliers who are deceased and for whom claims are submitted to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and Part A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on change request (CR) 6984 and explains how claims should be submitted by representatives of deceased providers who had obtained an NPI prior to death. A claim submitted after May 23, 2007, for a deceased provider who had an NPI will be rejected by Medicare because the provider's NPI was
Deactivated in the Medicare claims processing system due to the provider’s death. When a deceased provider’s claim is rejected by a Medicare contractor because of the absence of an NPI, the claim submitter is expected to contact the Medicare contractor to discuss payment of the claim and the provider’s death.

The Medicare contractor will ask the representative of the provider’s estate to submit the claim in paper format and will instruct the representative that Item 19 of the Form CMS-1500 claim must be annotated to state that the provider is deceased.

Additional Information
If you have questions, please contact your Medicare carrier, DME MAC, or A/B 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.

The official instruction, CR6984, issued to your Medicare contractor regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R799OTN.pdf on the CMS website.

National Modifier and Condition Code to Identify Items or Services Related to the 2010 Oil Spill in the Gulf of Mexico

MLN Matters® Number: MM7087
Related Change Request (CR) #: 7087
Related CR Release Date: August 6, 2010
Effective Date: April 20, 2010
Related CR Transmittal #: R2021CP
Implementation Date: January 3, 2011

Provider Types Affected
This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries related, in whole or in part, to the 2010 oil spill in the Gulf of Mexico.

Provider Action Needed
This article is based on Change Request (CR) 7087 which identifies a new modifier and a new condition code that must be used to identify items or services related to the 2010 oil spill in the Gulf of Mexico. Be sure your billing staff is aware of these changes. You should begin to place the modifier or condition code on claims submitted as of January 3, 2011.

Background
As a result of the oil spill in the Gulf of Mexico, the Centers for Medicare & Medicaid Services (CMS) plans to monitor the potential health and cost impacts of the oil spill on Medicare beneficiaries, in both the short and long-term. In order to ensure that such health care services and costs are properly identified, CMS is requiring that every Medicare Fee-For-Service claim be specifically identified if it is for an item or service furnished to a Medicare beneficiary, where the provision of such item or service is related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico (hereafter referred to as the “Gulf oil spill”) and/or circumstances related to such oil spill, including but not limited to subsequent clean-up activities.

Claims from physicians, other practitioners, and suppliers must be annotated with the modifier “CS” for each line item where the item or service is so related. Similarly, claims from institutional billers must be annotated with a condition code of “BP” when the entire claim is so related or with the “CS” modifier for each relevant line item when only certain line items are so related. The modifier and condition code are to be used for claims with dates of service on or after April 20, 2010.

The long description of the CS modifier is as follows: “Item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities.”
The short description of the CS modifier is: “Gulf Oil Spill Related.”

The title of the BP condition code is “Gulf oil spill related” and its definition is as follows: “This code identifies claims where the provision of all services on the claim are related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico and/or circumstances related to such spill, including but not limited to subsequent clean-up activities.”

Note: CMS requests provider, physician and supplier assistance in identifying previously processed claims related to an illness, injury or condition caused or exacerbated either directly or indirectly by the 2010 Gulf oil spill. CMS encourages providers, physicians and suppliers to contact their Medicare contractor to identify services or claims – submitted and processed prior to the creation of the Gulf oil spill modifier and condition code – that should have the CS modifier and/or the BP condition code appended.

Additional Information
If you have questions, please contact your Medicare MAC 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 (CR7087) issued to your Medicare MAC, carrier and/or FI is available at http://www.cms.gov/Transmittals/downloads/R2021CP.pdf on the CMS website.

Outpatient Therapy Cap Values for CY 2011
MLN Matters® Number: MM7107
Related Change Request (CR) #: 7107
Related CR Release Date: October 22, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2073CP
Implementation Date: January 3, 2011

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), and/or Regional Home Health Intermediaries (RHHIs)) for therapy services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7107, which describes the Centers for Medicare & Medicaid Services (CMS) policy for outpatient therapy caps for Calendar Year (CY) 2011. No change to the exceptions process is anticipated, if it should be extended into 2011. Be sure billing staff is aware of the updates.

Background
The Balanced Budget Act of 1997 set therapy caps, which change annually, for Part B Medicare patients. The Deficit Reduction Act of 2005 allowed CMS to establish a process for exceptions to therapy caps for medically necessary services. The Affordable Care Act extended exceptions to therapy caps through December 31, 2010.

Therapy caps for 2011 will be $1870. The exceptions process will continue unchanged for the time frame directed by the Congress.

Note that the limitations apply to outpatient services and do not apply to Skilled Nursing Facility (SNF) residents in a covered Part A stay, including swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services billed under the Home Health PPS, inpatient hospitals or the outpatient department of hospitals, including critical access hospitals.

Additional Information
The official instruction, CR 7170, issued to your FI, carrier, A/B MAC, or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2073CP.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.

Additional information concerning outpatient therapy services may be found at http://www.cms.hhs.gov/therapyservices on the CMS website.

Update to Medicare Deductible, Coinsurance and Premium Rates for 2011
MLN Matters® Number: MM7224
Related Change Request (CR) #: 7224
Related CR Release Date: November 19, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R65GI
Implementation Date: January 3, 2011

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

Impact on Providers
This article is based on Change Request (CR) 7224 which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2011.
Background

2011 Part A - Hospital Insurance (HI)

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Note: An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness. The 2011 inpatient deductible is $1132.00. The coinsurance amounts are shown below in the following table:

2011 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2011, the standard premium for SMI services is $115.40 a month; the deductible is $162.00 a year; and the coinsurance is 20%. The Part B premium is influenced by the beneficiary’s income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 7224, which is available at http://www.cms.hhs.gov/Transmittals/downloads/R65GI.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information

The official instruction, CR 7224, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R65GI.pdf on the CMS website.

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

Results of the 2010 Medicare Contractor Provider Satisfaction Survey (MCPSS)

MLN Matters® Number: SE1030
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected

This article is informational only for all physicians, providers, and suppliers billing the Medicare program.

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the annual MCPSS by the Centers for Medicare & Medicaid Services (CMS) to assess provider satisfaction with service from Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

Background

The MCPSS offers Medicare Fee-For-Service (FFS) providers an opportunity to give CMS feedback on their satisfaction, attitudes, perceptions, and opinions about the services provided by their respective contractor. The MCPSS elicits information from a sample of hospitals, physicians, Skilled Nursing Facilities (SNFs), home health agencies, clinical laboratories, and other providers and suppliers.

Survey questions focus on seven key business functions of the provider-contractor relationship: provider inquiries, provider outreach & education, claims processing, appeals, provider enrollment, medical review, and provider audit & reimbursement. The 2010 MCPSS survey questions used a new fully labeled rating scale of 1 to 5, “1” representing “very dissatisfied” and “5” representing “very satisfied”.

CMS distributed the 2010 survey to approximately 33,000 randomly selected providers, including physicians and other health care practitioners, suppliers, and institutional facilities that serve Medicare beneficiaries across the country. Those health care providers selected to participate in this year’s survey were notified in January.

In January 2011, the next MCPSS will be distributed to a new sample of approximately 33,000 Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2011 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.
Key Points/2010 Results

- Of all providers who responded, more than 69 percent stated they were satisfied or very satisfied with their contractor’s overall performance and 13 percent were dissatisfied or very dissatisfied with their contractor’s overall performance.
- Audit & Reimbursement and Claims Processing business functions were rated with the highest level of provider satisfaction.
- High satisfaction was also expressed by hospices, End Stage Renal Disease (ESRD) providers, and Rural Health clinics; while low satisfaction was expressed by licensed practitioners and laboratories.
- Individual results were provided to Medicare contractors for their use in process improvement activities.
- CMS is gradually migrating to a fully Web-based survey. The migration to the Web mode of response this year reached an overall total of 65 percent.
- The public report may be found at http://www.cms.gov/MCPSS/ on the CMS website.

Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

For more information about the MCPSS, please visit http://www.cms.gov/MCPSS/ on the CMS website.

2010 - 2011 Seasonal Influenza (Flu) Resources for Health Care Professionals

MLN Matters Number: SE1031 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 November 29, 2010, to include a reference to MLN Matters* article MM7234 (New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines). All other information is the same.

Provider Types Affected

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

Provider Action Needed

- Keep this Special Edition MLN Matters article and refer to it throughout the 2010 - 2011 flu season.
- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the seasonal flu and serious complications by getting a seasonal flu shot.
- Continue to provide the seasonal flu shot as long as you have vaccine available, even after the new year.
- Don’t forget to immunize yourself and your staff.

Introduction

Annual outbreaks of seasonal flu typically occur from the late fall through early spring. Typically, 5 to 20 percent of Americans catch the seasonal flu, with about 36,000 people dying from flu-related causes. Complications of flu can include pneumonia, ear infections, sinus infections, dehydration, and even death.

The Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare Part B reimburses health care providers for seasonal flu vaccines and their administration. (Medicare provides coverage of the seasonal flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) All adults 65 and older should get seasonal flu vaccine. People with Medicare who are under 65 but have chronic illness, including heart disease, lung disease, diabetes or end-stage renal disease should get a seasonal flu shot.

Get the Flu Vaccine, Not the Flu!

Unlike last flu season patients needed to get both a seasonal vaccine and a separate vaccine for the H1N1 virus, this season, a single seasonal flu vaccine will protect your patients, your staff, and yourself.

The seasonal flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by using every office visit as an opportunity to recommend they take advantage of the annual seasonal flu shot benefit covered by Medicare. And don’t forget, health care providers and their staff can spread the highly contagious flu virus to their patients. Don’t forget to immunize yourself and your staff.

The following educational products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

Educational Products for Health Care Professionals

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

1. MLN Matters Seasonal Influenza Articles

Reminder for Roster Billing and Centralized INSIDER DME MAC Jurisdiction C Update to Medicare Claims Processing Manual, Influenza Vaccine Payment Allowances – Annual Professionals MLN Seasonal Influenza Related Products for Health Care 2. Reporting of Diagnosis Code V06.6 on Influenza Guidelines for Payment of Vaccine (Pneumococcal MM 7124: 2010 MLNMattersArticles/downloads/MM7124.pdf on the CMS website. MM6608: Influenza Vaccine Payment Allowances – Annual Update for 2009-2010 Season at MM5511: Update to Medicare Claims Processing Manual, Chapter 18, Section 10 for Part B Influenza MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine at MM7234: New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines at 2. MLN Seasonal Influenza Related Products for Health Care Professionals Quick Reference Information: Medicare Part B Immunization Billing - This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF at The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Third Edition - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file at The Medicare Preventive Services Series Part 1 Web-Based Training Course (WBT) – This WBT contains lessons Medicare-covered preventive vaccinations, including the seasonal influenza vaccine. To take the course, visit the Medicare Preventive Services Educational Products page at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the internet. Scroll down to “Related Links Inside CMS” and choose “Web-Based Training (WBT) Modules”. Medicare Preventive Services Adult Immunizations Brochure - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Available as a downloadable PDF file at MM5511: Update to Medicare Claims Processing Manual, Chapter 18, Section 10 for Part B Influenza MM4240: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration at MM5037: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine at MM7234: New HCPCS Q-codes for 2010-2011 Seasonal Influenza Vaccines at MLN Preventive Services Educational Products Page at MLN Preventive Services Educational Products Web Page - This Medicare Learning Network (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS health care professionals. PDF files provide product ordering information and links to all downloadable products, including those related to the seasonal influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark http://www.cms.gov/MLNProducts/35_PreventiveServices.asp for easy access. 3. Other CMS Resources CMS Adult Immunizations Web Page is at CMS Frequently Asked Questions are available at Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations available at Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services available at Medicare Part B Drug Average Sales Price Payment Amounts Influenza and Pneumococcal Vaccines Pricing found at 4. Other Resources The following non-CMS resources are just a few of the many available in which clinicians may find useful information and
tools to help increase seasonal flu vaccine awareness and utilization during the 2009 – 2010 flu season:

- Advisory Committee on Immunization Practices are at http://www.cdc.gov/vaccines/recs/acip/default.htm on the Internet.
- American Lung Association’s Influenza (Flu) Center is at http://www.lungusa.org on the Internet. This website provides a flu clinic locator at http://www.flucliniclocator.org on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- Other sites with helpful information include:
  - Centers for Disease Control and Prevention - http://www.cdc.gov/flu;
  - Food and Drug Administration - http://www.fda.gov;
  - Immunization Action Coalition - http://www.immunize.org;
  - Indian Health Services - http://www.ihs.gov/;
  - National Alliance for Hispanic Health - http://www.hispanichealth.org;
  - National Foundation For Infectious Diseases - http://www.nfids.org/influenza;
  - National Network for Immunization Information - http://www.immunizationinfo.org;
  - National Vaccine Program - http://www.hhs.gov/nvpo;
  - Partnership for Prevention - http://www.prevent.org; and

Beneficiary Information

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

Partial Code Freeze Prior to ICD-10 Implementation

MLN Matters® Number: SE1033
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected

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

What You Need to Know

At the ICD-9-CM Coordination & Maintenance (C&M) Committee Meeting, held on September 15, 2010, it was announced that the committee had finalized the decision to implement a partial freeze for both ICD-9-CM codes and ICD-10-CM and ICD-10-PCS codes prior to implementation of ICD-10 on October 1, 2013.

Considerable interest was expressed in dramatically reducing the number of annual updates to both coding systems. It was suggested that such a reduction in code updates would allow vendors, providers, system maintainers, payers, and educators a better opportunity to prepare for the implementation of ICD-10. Additional public comments on this issue were received prior to this meeting.

The partial freeze will be implemented as follows:

- The last regular annual update to both ICD-9 and ICD-10 code sets will be made on October 1, 2011.
- On October 1, 2012 there will be only limited code updates to both ICD-9-CM and ICD-10 code sets to capture new technology and new diseases.
- On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses. There will be no updates to ICD-9-CM on October 1, 2013 as the system will no longer be a HIPAA standard.

On October 1, 2014, regular updates to ICD-10 will begin. The ICD-9 Coordination & Maintenance Committee will continue to meet twice a year during the freeze. At these meetings the public will be allowed to comment on whether or not requests for new diagnosis and procedure codes should be created based on the need to capture new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on or after October 1, 2014, once the partial freeze is ended.

To view the transcript of the meeting, go to: http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the ’091510_Morning_Transcript’ file. This section appears on page 4 of the 78-page document.

To view the Summary Report of the meeting, go to: http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp on the CMS website. From there, select the September 15-16, 2010, meeting documents and transcripts from the Downloads section, and then from the ZIP files, select the ’091510_ICD9_Meeting_Summary_report.pdf’ file. Information on the Code Freeze begins on page 5.

Additional Information

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

In addition, the following CMS resources are available to assist in your transition to ICD-10:
Medicare Fee-for-Service Provider Resources Web Page - This site links Medicare Fee-For-Service (FFS) providers to information and educational resources that are useful for all providers to implement and transition to ICD-10 medical coding in a 5010 environment. As educational materials become available specifically for Medicare FFS providers, they will be posted to this web page. Bookmark http://www.cms.gov/ICD10/06_MedicareFeeforServiceProviderResources.asp and check back regularly for access to ICD-10 implementation information of importance to you. Note: Use the links on the left side of the web page to navigate to ICD-10 and 5010 information applicable to your specific interest.

CMS Sponsored National Provider Conference Calls - During the ICD-10 implementation period, CMS will periodically host national provider conference calls focused on various topics related to the implementation of ICD-10. Calls will include a question and answer session that will allow participants to ask questions of CMS subject matter experts. These conference calls are offered free of charge and require advance registration. Continuing education credits may be awarded for participation in CMS national provider conference calls. For more information, including announcements and registration information for upcoming calls, presentation materials and written and audio transcripts of previous calls, please visit http://www.cms.gov/ICD10/Tel10/list.asp#TopOfPage on the CMS website.

Frequently Asked Questions (FAQs) - To access FAQs related to ICD-10, please visit the CMS ICD-10 web page at http://www.cms.gov/ICD10/, select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the “Related Links Inside CMS” section and select “ICD-10 FAQs”. Please check the ICD-10 FAQ section regularly for newly posted or updated ICD-10 FAQs.

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

- Workgroup for Electronic Data Interchange (WEDI) http://www.wedi.org and

Claims

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

MLN Matters® Number: MM6625 Revised
Related Change Request (CR) #: 6625
Related CR Release Date: December 3, 2010
Effective Date: April 1, 2011
Related CR Transmittal #: R2112CP
Implementation Date: July 5, 2011

Note: This article was revised on December 6, 2010, to reflect a revision to CR 6625. The implementation date has been changed to July 5, 2011. The CR release date, transmittal number, and the Web address for accessing CR 6625 has been revised. All other information is the same.

Provider Types Affected

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

What You Need to Know

CR 6625, from which this article is taken, instructs Medicare contractors (FIs, RHHIs, carriers, A/B MACs, and DME MACs) and shared system maintainers (SSM) to implement (effective April 1, 2011) an automated process to reopen Group Health Plan (GHP) Medicare Secondary Payer (MSP) claims when related MSP data is deleted or terminated after claims were processed subject to the beneficiary record on Medicare’s database. Make sure that your billing staffs are aware of these new Medicare contractor instructions. Please see the Background section, below, for more details.

Background

MSP GHP claims were not automatically reprocessed in situations where Medicare became the primary payer after an MSP GHP record had been deleted or when an MSP GHP record was terminated after claims were processed subject to MSP data in Medicare files. It was the responsibility of the beneficiary, provider, physician or other suppliers to contact the Medicare contractor and request that the denied claims be reprocessed when reprocessing was warranted. However, this process places a burden on the beneficiary, physician, or other supplier and CR 6625 eliminates...
this burden. As a result of CR 6625, Medicare will implement an automated process to:

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

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

If providers, physicians or other suppliers believe some claim adjustments were missed please contact your Medicare contractor regarding those missing adjustments.

Additional Information

You can find the official instruction, CR6625, issued to your FI, RHHI, carrier, A/B MAC, or DME MAC by visiting http://www.cms.gov/Transmittals/downloads/R2112CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

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 on the CMS website.

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

MLN Matters® Number: MM7073
Related Change Request (CR) #: 7073
Related CR Release Date: November 12, 2010
Effective Date: July 1, 2011
Related CR Transmittal #: R808OTN
Implementation Date: July 5, 2011

Provider Types Affected

Suppliers who submit claims to Medicare DME Medicare Administrative Contractors (DME MACs) for DMEPOS services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7073. The Centers for Medicare & Medicaid Services (CMS) is issuing CR7073 to provide further guidance to suppliers of DMEPOS, regarding licensing, accreditation, or other mandatory quality requirements that may apply. DMEPOS suppliers should be aware that if they are not identified by the National Supplier Clearing House-Medicare Administrative Contractor (NSC-MAC) as being accredited to supply the specific product/service AND they are not exempt from accreditation, their claims will be denied automatically by Medicare.

Background

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

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

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

- Physicians (as defined in Section 1861(r) of the Act);
- Physical Therapists;
- Occupational Therapists;
- Qualified Speech-Language Pathologists;
- Physician Assistants;
- Nurse Practitioners;
- Clinical Nurse Specialists;
- Certified Registered Nurse Anesthetists;
- Certified Nurse-Midwives;
- Clinical Social Workers;
- Clinical Psychologists;
- Registered Dietitians; and
- Nutritional Professionals.
Additionally, MIPPA allows the Secretary to specify “other persons” that are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, “such other persons” are specifically defined as the following practitioners:

- Orthotists;
- Prosthetists;
- Opticians; and
- Audiologists, and

Pharmacies (. that have an NSC-MAC approved “Attestation for Exemption from Accreditation for a Medicare Enrolled Pharmacy. (see the NSC-MAC website at Palmettogba.com or the CMS website) (In accordance with Section 3109(a) of the Patent Protection and Affordable Care Act.)

Key Points
All supplier types (except those listed above) who furnish items and services requiring accreditation, directly or as a subcontractor for another entity, must have submitted evidence of accreditation by an accreditation organization designated by the Secretary on or after October 1, 2009.

Edits for the Healthcare Common Procedure Coding System (HCPCS) codes in the product categories designated by MIPPA as requiring accreditation will be in effect. Effective for claims with dates of service on or after July 5, 2011, this Medicare systems edit will automatically deny claims for these codes unless:

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

When claims are denied, DME MACs will use the following messages:

- **Remark Code N211** – “Alert: You may not appeal this decision” and
- **Claim Adjustment Reason Code B7** – “This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.”

Note: Products and services requiring accreditation found on CMS 855S, Section 2D next to the NSC-MAC product codes along with HCPCS codes may be found in Attachment B in CR 7073. Their corresponding HCPCS codes may be found in Attachment C. The web address of CR 7073 can be found in the next section of this article.

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.


To review the CR6566, the initial article listing HCPCS codes, you may go to [http://www.cms.gov/MLNMattersArticles/downloads/MM6566.pdf](http://www.cms.gov/MLNMattersArticles/downloads/MM6566.pdf) on the CMS website.


### Reasonable Charge Update for 2011 for Splints, Casts, and Certain Intraocular Lenses

**MLN Matters® Number:** MM7225

**Related Change Request (CR) #:** 7225

**Related CR Release Date:** November 19, 2010

**Effective Date:** January 1, 2011

**Related CR Transmittal #:** R2100CP

**Implementation Date:** January 3, 2011

**Provider Types Affected**
This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

**Provider Action Needed**
Change Request (CR) 7225, from which this article is taken, instructs your carriers, FIs, and MACs how to calculate reasonable charges for the payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Make sure your billing staff is aware of these changes.

**Background**
Payment continues to be made on a reasonable charge basis for splints, casts, and for intraocular lenses implanted (codes V2630, V2631, and V2632) in a physician’s office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Beginning January 1, 2011, reasonable charges will no longer be calculated for payment of home dialysis supplies and equipment for Method II End Stage Renal Disease (ESRD) patients. Section 153 of Medicare Improvements for Patients and Providers Act (MIPPA) amended section 1881(b) of the Act to require the implementation of an ESRD bundled payment system effective January 1, 2011. The ESRD prospective payment will provide an all-inclusive single payment to ESRD facilities (i.e. hospital-based providers of services and renal dialysis facilities) that will cover all the resources used in providing outpatient dialysis treatment, including dialysis supplies and equipment that are currently separately payable to Method II DME suppliers.
CR 7225 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in calendar year 2011. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501. The Inflation Indexed Charge (IIC) is calculated using the lowest of the reasonable charge screens from the previous year updated by an inflation adjustment factor or the percentage change in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. The 2011 payment limits for splints and casts will be based on the 2010 limits that were announced in CR 6691 last year, increased by 1.1 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2010. The IIC update factor for 2011 is 1.1 percent.

A list of the 2011 payment limits for splints and casts are listed in the table that follows.

<table>
<thead>
<tr>
<th>Code</th>
<th>Payment Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4565</td>
<td>$7.84</td>
</tr>
<tr>
<td>Q4001</td>
<td>$44.60</td>
</tr>
<tr>
<td>Q4002</td>
<td>$168.58</td>
</tr>
<tr>
<td>Q4003</td>
<td>$32.04</td>
</tr>
<tr>
<td>Q4004</td>
<td>$110.92</td>
</tr>
<tr>
<td>Q4005</td>
<td>$11.81</td>
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<tr>
<td>Q4006</td>
<td>$26.62</td>
</tr>
<tr>
<td>Q4007</td>
<td>$5.92</td>
</tr>
<tr>
<td>Q4008</td>
<td>$13.31</td>
</tr>
<tr>
<td>Q4009</td>
<td>$7.89</td>
</tr>
<tr>
<td>Q4010</td>
<td>$17.75</td>
</tr>
<tr>
<td>Q4011</td>
<td>$3.94</td>
</tr>
<tr>
<td>Q4012</td>
<td>$8.88</td>
</tr>
<tr>
<td>Q4013</td>
<td>$14.36</td>
</tr>
<tr>
<td>Q4014</td>
<td>$24.21</td>
</tr>
<tr>
<td>Q4010</td>
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<td>Q4011</td>
<td>$3.94</td>
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<tr>
<td>Q4012</td>
<td>$8.88</td>
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<tr>
<td>Q4013</td>
<td>$14.36</td>
</tr>
<tr>
<td>Q4014</td>
<td>$24.21</td>
</tr>
<tr>
<td>Q4015</td>
<td>$7.18</td>
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<tr>
<td>Q4016</td>
<td>$12.10</td>
</tr>
<tr>
<td>Q4017</td>
<td>$8.30</td>
</tr>
<tr>
<td>Q4018</td>
<td>$13.23</td>
</tr>
</tbody>
</table>

Additional Information


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

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**Claim Status Category & Claim Status Code Update**

**MLN Matters® Number:** MM7259  
**Related Change Request (CR) #:** 7259  
**Related CR Release Date:** December 17, 2010  
**Effective Date:** April 1, 2011  
**Related CR Transmittal #:** R2120CP  
**Implementation Date:** April 4, 2011  
**Provider Types Affected**

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

**Provider Action Needed**

This article, based on Change Request (CR) 7259, explains that the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors with the Health Claim Status Request and Response ASC X12N 276/277 along with the 277 Health Care Claim Acknowledgement were updated during the January 2011 meeting of the national Code Maintenance Committee and code changes approved at that meeting are to be posted at [http://www.wpc-edi.com/content/view/180/223/](http://www.wpc-edi.com/content/view/180/223/) on or about March 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. Medicare contractors will implement these changes on April 4, 2011. All providers should ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

**Background**

The Health Insurance Portability and Accountability Act requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1 and 005010X212). CMS has also adopted as the CMS standard for contractor use the X12 277 Health Care Claim Acknowledgement (005010X214) as the X12 5010 required method to acknowledge the inbound 837 (Institutional or Professional) claim format. These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

**Additional Information**

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

Fees & ASP Pricing

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

MLN Matters® Number: MM7188
Related Change Request (CR) #: 7188
Related CR Release Date: October 15, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2067CP
Implementation Date: January 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) 7188 and instructs Medicare contractors to download and implement the January 2011 ASP drug pricing file for Medicare Part B drugs; and, if released by the Centers for Medicare & Medicaid Services (CMS), also the revised October 2010, July 2010, April 2010, and January 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 January 3, 2011, with dates of service January 1, 2011, through March 31, 2011. See the Background and Additional Information Sections of this article for further details regarding these changes.

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

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

<table>
<thead>
<tr>
<th>Files</th>
<th>Effective Dates of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>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>
<tr>
<td>July 2010 ASP and ASP NOC files</td>
<td>July 1, 2010, through September 30, 2010</td>
</tr>
<tr>
<td>April 2010 ASP and ASP NOC files</td>
<td>April 1, 2010, through June 30, 2010</td>
</tr>
<tr>
<td>January 2010 ASP and ASP NOC files</td>
<td>January 1, 2010, through March 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/Transmittals/downloads/R2067CP.pdf on the CMS website.

Calendar Year (CY) 2011 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

MLN Matters® Number: MM7248 Revised
Related Change Request (CR): # 7248
Related CR Release Date: January 24, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R2142CP
Implementation Date: January 3, 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, based on Change Request (CR) 7248, advises you of the CY 2011 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. The annual update process for the DMEPOS fee schedule is documented in the Medicare Claims Processing Manual, Chapter 23, Section 60 at http://www.cms.gov/downloads/clm104c23.pdf on the Centers for Medicare & Medicaid Services (CMS) website. Key points about these changes are summarized in the Background section below. These changes are effective for
DMEPOS provided on or after January 1, 2011. Be sure your billing staffs are aware of these changes.

**Background and Key Points of CR7248**


### 2011 Update to Labor Payment Rates

2011 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 1.1 percent effective for dates of service on or after January 1, 2011 through December 31, 2011, and those rates are as follows:

<table>
<thead>
<tr>
<th>STATE</th>
<th>K0739</th>
<th>L4205</th>
<th>L7520</th>
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<tbody>
<tr>
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<tr>
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<td>27.4</td>
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<td>AZ</td>
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<td>27.4</td>
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<tr>
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</tr>
<tr>
<td>MT</td>
<td>13.56</td>
<td>20.19</td>
<td>34.25</td>
</tr>
</tbody>
</table>

### HCPCS Code Updates

The following new codes are effective as of January 1, 2011:

- A4566, A9273, and EO446 all of which have no assigned payment category;
- A7020,E2622, E2623, E2624, and E2625 in the inexpensive/routinely purchased (DME) payment category;
- E1831 in the capped rental payment category (DME);
- L3674, L4631, L5961, L8693, Q0478, and Q0479, in the prosthetics/orthotics payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2011 DMEPOS Fee Schedule Update, when applicable. The DME MACs will establish local fee schedule amounts to pay claims for the new codes, where applicable, from January 1, 2011 through June 30, 2011. The new codes are not to be used for billing purposes until they are effective on January 1, 2011.

The following codes are being deleted from the HCPCS effective January 1, 2011, and are therefore being removed from the DMEPOS fee schedule files:

- E0220, E0230, and E0238
- K0734, K0735, K0736, and K0737
- L3672 and L3673.

For gap-filling purposes, the 2010 deflation factors by payment category are listed as follows:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.502</td>
<td>Oxygen</td>
</tr>
<tr>
<td>0.506</td>
<td>Capped Rental</td>
</tr>
<tr>
<td>0.507</td>
<td>Prosthetics and Orthotics</td>
</tr>
<tr>
<td>0.643</td>
<td>Surgical Dressings</td>
</tr>
<tr>
<td>0.700</td>
<td>Parenteral and Enteral Nutrition</td>
</tr>
</tbody>
</table>

### Specific Coding and Pricing Issues

Therapeutic shoes and insert fee schedule amounts were implemented as part of the January 2005 Fee Schedule Update as described in Change Request 3574 (Transmittal 369) which may be reviewed at [http://www.cms.gov/transmittals/Downloads/R369CP.pdf](http://www.cms.gov/transmittals/Downloads/R369CP.pdf) on the CMS website. The payment amounts for shoe modification codes A5503 through A5507 were established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). The fees for codes A5512 and A5513 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004.

As part of this update, CMS is revising the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code as follows:

- Fees for A5512 and A5513 will be weighted based on the approximate total allowed services for each code for items furnished during the Calendar Year 2009;
- The fee schedules for codes A5503 through A5507 are being revised effective January 1, 2011, to reflect this change.

### Power-Driven Wheelchairs

In accordance with Section 3136(a)(1) of The Affordable Care Act of 2010, effective for claims with dates of service on or after January 1, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule for power-driven wheelchairs furnished on or after January 1, 2011, is revised to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly...
rental method and 6 percent (instead of 7.5 percent) for each of the remaining rental months 4 through 13. The purchase fee schedule amount for complex rehabilitation power wheelchairs is equal to the rental fee (for months 1-3) divided by 0.15. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B of CR 7248. This attachment identifies those codes where payment, when applicable, should be made at 15 percent of the purchase price for months 1 through 3 and 6 percent of the purchase price for months 4 through 13.

These changes do not apply to rented power-driven wheelchairs for which the date of service for the initial rental month is prior to January 1, 2011. For these items, payment for rental claims with dates of service on or after January 1, 2011, will continue to be based on 10 percent of the purchase price for rental months 2 and 3 and 7.5 percent of the purchase price for rental months 4 through 13.

Also, Section 3136(c)(2) of The Affordable Care Act specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the Medicare DMEPOS Competitive Bidding Program. MLN Matters® article MM7181 at http://www.cms.gov/MLNMattersArticles/downloads/MM7181.pdf discusses these changes. For power-driven wheelchairs furnished on a rental basis with dates of service prior to January 1, 2006, for which the beneficiary did not elect the purchase option in month 10 and continues to use, contractors shall continue to pay the maintenance and servicing payment amount at 10% of the purchase price. In these instances, suppliers should continue to use the following HCPCS codes, with the MS modifier, for billing maintenance and servicing, as appropriate:

- **K0010 Standard** - Weight Frame Motorized/Power Wheelchair
- **K0011 Standard** - Weight Frame Motorized/Power Wheelchair with Programmable Control Parameters for Speed Adjustment, Tremor Dampening, Acceleration Control and Braking
- **K0012 Lightweight Portable Motorized/Power Wheelchair**
- **K0014 Other Motorized/Power Wheelchair Base**

The rental fee schedule payment amounts for codes K0010, K0011 and K0012 will continue to reflect 10 percent of the wheelchair’s purchase price.

**CY 2011 Fee Schedule Update Factor**

The DMEPOS fee schedule amounts are to be updated for 2011 by the percentage increase in the Consumer Price Index (CPI) for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. Also beginning with CY 2011, Section 3401 of The Affordable Care Act requires that the increase in the CPI-U be adjusted by changes in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The amendment specifies the application of the MFP may result in an update "being less than 0.0 for a year, and may result in payment rates being less than such payment rates for the preceding year". For CY 2011, the MFP adjustment is 1.2 percent and the CPI-U percentage increase is 1.1 percent. Therefore, the 1.1 percent increase in the CPI-U is reduced by the 1.2 percent increase in the MFP, resulting in a net reduction of 0.1 percent for the MFP-adjusted update factor. In other words, the MFP-adjusted update factor of -0.1 percent is applied to the applicable CY 2010 DMEPOS fee schedule amounts.

**2011 National Monthly Payment Amounts for Stationary Oxygen Equipment**

CMS will also implement the 2011 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2011. The fee schedule file is being revised to include the new national 2011 monthly payment rate of $173.31 for stationary oxygen equipment. The payment rates are being adjusted on an annual basis, as necessary, to ensure budget neutrality of the addition of the new Oxygen Generating Portable Equipment (OGPE) class. The revised 2011 monthly payment rate of $173.31 includes the -0.1 percent MFP-adjusted update factor. The budget neutrality adjustment and the MFP-adjusted covered item update factor for 2011 caused the 2010 rate to change from $173.17 to $173.31.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

**2011 Maintenance and Service Payment Amount for Certain Oxygen Equipment**

Payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier’s or manufacturer’s warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

The 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator which resulted in a payment of $66 for CY 2010. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Social Security Act. The 2010 maintenance and servicing fee is adjusted by the -0.1 percent MFP-adjusted update factor to yield a CY 2011 maintenance and servicing fee of $65.93 for oxygen concentrators and transfilling equipment.

**Specific Billing Issues**

Effective January 1, 2011, the payment category for code E0575 (Nebulizer, Ultrasonic, Large Volume) is being revised to move
the nebulizer from the DME payment category for frequent and substantial servicing to the DME payment category for capped rental items. The first claim received for each beneficiary for this code with a date of service on or after January 1, 2011 will be counted as the first rental month in the cap rental period.

Code A7020 (Interface for Cough Stimulating Device, Includes All Components, Replacement Only) is added to the HCPCS file effective January 1, 2011. Items coded under this code are accessories used with the capped rental Durable Medical Equipment cough stimulating device coded at E0482. Section 110.3, Chapter 15 of the Medicare Benefit Policy Manual at http://www.cms.gov/Manuals/downloads/bp102c15.pdf provides that reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary Durable Medical Equipment only if the beneficiary owns or is purchasing the equipment. Therefore, separate payment will not be made for the replacement of accessories described by code A7020 until after the 13-month rental cap has been reached for capped rental code E0482.

The following new codes are being added to the HCPCS file, effective January 1, 2011, to describe replacement accessories for Ventricular Assist Devices (VADs):

- Q0478 (Power Adaptor for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type); and
- Q0479 (Power Module for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only).

Similar to the other VAD supplies and accessories coded at Q0480 thru Q0496, Q0497 thru Q0502, Q0504 and Q0505, CMS has determined the reasonable useful lifetime for codes Q0478 and Q0479 to be one year. CMS is establishing edits to deny claims before the lifetime of these items has expired. Suppliers and providers will need to add HCPCS modifier RA to claims for codes Q0478 and Q0479 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Additionally, code Q0489 (Power Pack Base for Use With Electric/Pneumatic Ventricular Assist Device, Replacement Only) should not be used to bill separately for a VAD replacement power module or a battery charger in instances where the power module and battery charger are not integral and are furnished as separate components.

Additional Information The official instruction, CR7248, issued to your carrier, FI, RHHI, A/B MAC, and DME/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2142CP.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.
### External Infusion Pumps

#### Added Code

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#### Discontinued Code

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<tr>
<td>J9110</td>
<td>INJECTION, CYTARABINE, 500 MG</td>
<td>J9100</td>
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<tr>
<td>J9375</td>
<td>VINCRISTINE SULFATE, 2 MG</td>
<td>J9370</td>
</tr>
<tr>
<td>J9380</td>
<td>VINCRISTINE SULFATE, 5 MG</td>
<td>J9370</td>
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### Home Dialysis Supplies and Equipment

#### Invalid for Submission to DME MAC

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#### Invalid for Submission to DME MAC

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<tr>
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<th>Narrative</th>
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<tbody>
<tr>
<td>A4651</td>
<td>CALIBRATED MICROCAPILLARY TUBE, EACH</td>
</tr>
<tr>
<td>A4652</td>
<td>MICROCAPILLARY TUBE SEALANT</td>
</tr>
<tr>
<td>A4653</td>
<td>PERITONEAL DIALYSIS CATHETER ANCHORING DEVICE, BELT, EACH</td>
</tr>
<tr>
<td>A4671</td>
<td>DISPOSABLE CYCLER SET USED WITH CYCLER DIALYSIS MACHINE, EACH</td>
</tr>
<tr>
<td>A4672</td>
<td>DRAINAGE EXTENSION LINE, STERILE, FOR DIALYSIS, EACH</td>
</tr>
<tr>
<td>A4673</td>
<td>EXTENSION LINE WITH EASY LOCK CONNECTORS, USED WITH DIALYSIS</td>
</tr>
<tr>
<td>A4674</td>
<td>CHEMICALS/ANTISEPTICS SOLUTION USED TO CLEAN/STERILIZE DIALYSIS EQUIPMENT, PER 8 OZ</td>
</tr>
<tr>
<td>A4680</td>
<td>ACTIVATED CARBON FILTER FOR HEMODIALYSIS, EACH</td>
</tr>
<tr>
<td>A4690</td>
<td>DIALYZER (ARTIFICIAL KIDNEYS), ALL TYPES, ALL SIZES, FOR HEMODIALYSIS, EACH</td>
</tr>
<tr>
<td>A4706</td>
<td>BICARBONATE CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON</td>
</tr>
<tr>
<td>A4707</td>
<td>BICARBONATE CONCENTRATE, POWDER, FOR HEMODIALYSIS, PER PACKET</td>
</tr>
<tr>
<td>A4708</td>
<td>ACETATE CONCENTRATE SOLUTION, FOR HEMODIALYSIS, PER GALLON</td>
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<tr>
<td>A4709</td>
<td>ACID CONCENTRATE, SOLUTION, FOR HEMODIALYSIS, PER GALLON</td>
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<tr>
<td>A4714</td>
<td>TREATED WATER (DEIONIZED, DISTILLED, OR REVERSE OSMOSIS) FOR PERITONEAL DIALYSIS, PER GALLON</td>
</tr>
<tr>
<td>A4719</td>
<td>“Y SET” TUBING FOR PERITONEAL DIALYSIS</td>
</tr>
<tr>
<td>A4720</td>
<td>DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 249CC, BUT LESS THAN OR EQUAL TO 999CC, FOR PERITONEAL DIALYSIS</td>
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<tr>
<td>A4721</td>
<td>DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 999CC BUT LESS THAN OR EQUAL TO 2999CC, FOR PERITONEAL DIALYSIS</td>
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<td>A4722</td>
<td>DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 2999CC BUT LESS THAN OR EQUAL TO 5999CC, FOR PERITONEAL DIALYSIS</td>
</tr>
<tr>
<td>A4723</td>
<td>DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 5999CC BUT LESS THAN OR EQUAL TO 9999CC, FOR PERITONEAL DIALYSIS</td>
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<td>A4724</td>
<td>DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 9999CC BUT LESS THAN OR EQUAL TO 19999CC, FOR PERITONEAL DIALYSIS</td>
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<tr>
<td>A4725</td>
<td>DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 19999CC BUT LESS THAN OR EQUAL TO 29999CC, FOR PERITONEAL DIALYSIS</td>
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<td>A4726</td>
<td>DIALYSATE SOLUTION, ANY CONCENTRATION OF DEXTROSE, FLUID VOLUME GREATER THAN 29999CC BUT LESS THAN OR EQUAL TO 59999CC, FOR PERITONEAL DIALYSIS</td>
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<tr>
<td>A4727</td>
<td>DIALYSATE SOLUTION, NON-DEXTROSE CONTAINING, 500 ML</td>
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<tr>
<td>A4730</td>
<td>FISTULA CANNULATION SET FOR HEMODIALYSIS, EACH</td>
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<tr>
<td>A4736</td>
<td>TOPICAL ANESTHETIC, FOR DIALYSIS, PER GRAM</td>
</tr>
<tr>
<td>A4737</td>
<td>INJECTABLE ANESTHETIC, FOR DIALYSIS, PER 10 ML</td>
</tr>
<tr>
<td>A4740</td>
<td>SHUNT ACCESSORY, FOR HEMODIALYSIS, ANY TYPE, EACH</td>
</tr>
<tr>
<td>A4750</td>
<td>BLOOD TUBING, ARTERIAL OR VENOUS, FOR HEMODIALYSIS, EACH</td>
</tr>
<tr>
<td>A4755</td>
<td>BLOOD TUBING, ARTERIAL AND VENOUS COMBINED, FOR HEMODIALYSIS, EACH</td>
</tr>
<tr>
<td>A4760</td>
<td>DIALYSATE SOLUTION TEST KIT, FOR PERITONEAL DIALYSIS, ANY TYPE, EACH</td>
</tr>
<tr>
<td>A4765</td>
<td>DIALYSATE CONCENTRATE, POWDER, ADDITIVE FOR PERITONEAL DIALYSIS, PER PACKET</td>
</tr>
<tr>
<td>A4766</td>
<td>DIALYSATE CONCENTRATE, SOLUTION, ADDITIVE FOR PERITONEAL DIALYSIS, PER 10 ML</td>
</tr>
<tr>
<td>A4770</td>
<td>BLOOD COLLECTION TUBE, VACUUM, FOR DIALYSIS, PER 50</td>
</tr>
<tr>
<td>A4771</td>
<td>SERUM CLOTTING TIME TUBE, FOR DIALYSIS, PER 50</td>
</tr>
<tr>
<td>A4772</td>
<td>BLOOD GLUCOSE TEST STRIPS, FOR DIALYSIS, PER 50</td>
</tr>
<tr>
<td>A4773</td>
<td>OCCULT BLOOD TEST STRIPS, FOR DIALYSIS, PER 50</td>
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<tr>
<td>A4774</td>
<td>AMMONIA TEST STRIPS, FOR DIALYSIS, PER 50</td>
</tr>
<tr>
<td>A4780</td>
<td>PROTAMINE SULFATE, FOR HEMODIALYSIS, PER 50 MG</td>
</tr>
<tr>
<td>A4860</td>
<td>DISPOSABLE CATHETER TIPS FOR PERITONEAL DIALYSIS, PER 10</td>
</tr>
<tr>
<td>A4870</td>
<td>PLUMBING AND/OR ELECTRICAL WORK FOR HOME HEMODIALYSIS EQUIPMENT</td>
</tr>
<tr>
<td>A4890</td>
<td>CONTRACTS, REPAIR AND MAINTENANCE, FOR HEMODIALYSIS EQUIPMENT</td>
</tr>
<tr>
<td>A4901</td>
<td>DRAIN BAG/BOTTLE, FOR DIALYSIS, EACH</td>
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<tr>
<td>A4913</td>
<td>MISCELLANEOUS DIALYSIS SUPPLIES, NOT OTHERWISE SPECIFIED</td>
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<tr>
<td>A4918</td>
<td>VENOUS PRESSURE CLAMP, FOR HEMODIALYSIS, EACH</td>
</tr>
<tr>
<td>A4928</td>
<td>SURGICAL MASK, PER 20</td>
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<tr>
<td>A4929</td>
<td>TOURNIQUET FOR DIALYSIS, EACH</td>
</tr>
<tr>
<td>A4930</td>
<td>CENTRIFUGE, FOR DIALYSIS</td>
</tr>
<tr>
<td>A4931</td>
<td>HEPARIN INFUSION PUMP FOR HEMODIALYSIS</td>
</tr>
<tr>
<td>A4932</td>
<td>AIR BUBBLE DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT</td>
</tr>
<tr>
<td>A4933</td>
<td>PRESSURE ALARM FOR HEMODIALYSIS, EACH, REPLACEMENT</td>
</tr>
<tr>
<td>A4934</td>
<td>BATH CONDUCTIVITY METER FOR HEMODIALYSIS, EACH</td>
</tr>
<tr>
<td>A4935</td>
<td>BLOOD LEAK DETECTOR FOR HEMODIALYSIS, EACH, REPLACEMENT</td>
</tr>
<tr>
<td>A4936</td>
<td>ADJUSTABLE CHAIR, FOR ESRD PATIENTS</td>
</tr>
<tr>
<td>A4937</td>
<td>TRANSOCUR PROTECTORS/FLUID BARRIERS, FOR HEMODIALYSIS, ANY SIZE, PER 10</td>
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<tr>
<td>A4938</td>
<td>UNIPUNCTURE CONTROL SYSTEM FOR HEMODIALYSIS</td>
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<tr>
<td>A4939</td>
<td>HEMODIALYSIS MACHINE</td>
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<tr>
<td>A4940</td>
<td>AUTOMATIC INTERMITTENT PERITONEAL DIALYSIS SYSTEM</td>
</tr>
<tr>
<td>A4941</td>
<td>CYCLER DIALYSIS MACHINE FOR PERITONEAL DIALYSIS</td>
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<tr>
<td>A4942</td>
<td>DELIVERY AND/OR INSTALLATION CHARGES FOR HEMODIALYSIS EQUIPMENT</td>
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</tbody>
</table>
Home Dialysis Supplies and Equipment
Invalid for Submission to DME MAC

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
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</thead>
<tbody>
<tr>
<td>E1610</td>
<td>REVERSE OSMOSIS WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS</td>
</tr>
<tr>
<td>E1615</td>
<td>DEIONIZER WATER PURIFICATION SYSTEM, FOR HEMODIALYSIS</td>
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<tr>
<td>E1620</td>
<td>BLOOD PUMP FOR HEMODIALYSIS, REPLACEMENT</td>
</tr>
<tr>
<td>E1625</td>
<td>WATER SOFTENING SYSTEM, FOR HEMODIALYSIS</td>
</tr>
<tr>
<td>E1630</td>
<td>RECIPROCATING PERITONEAL DIALYSIS SYSTEM</td>
</tr>
<tr>
<td>E1632</td>
<td>WEARABLE ARTIFICIAL KIDNEY, EACH</td>
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<tr>
<td>E1634</td>
<td>PERITONEAL DIALYSIS CLAMPS, EACH</td>
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<tr>
<td>E1635</td>
<td>COMPACT (PORTABLE) TRAVEL HEMODIALYZER SYSTEM</td>
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<tr>
<td>E1636</td>
<td>SOORBENT CARTRIDGES, FOR HEMODIALYSIS, PER 10</td>
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<td>E1637</td>
<td>HEMOSTATS, EACH</td>
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<tr>
<td>E1699</td>
<td>DIALYSIS EQUIPMENT, NOT OTHERWISE SPECIFIED</td>
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Intravenous Immune Globulin

Added Code

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<tr>
<td>J1599</td>
<td>INJECTION, IMMUNE GLOBULIN, INTRA VENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG</td>
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Lower Limb Prostheses

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<tr>
<td>L5961</td>
<td>ADDITION, ENDOSKELETAL SYSTEM, POLYCENTRIC HIP JOINT, PNEUMATIC OR HYDRAULIC CONTROL, ROTATION CONTROL, WITH OR WITHOUT FLEXION AND/OR EXTENSION CONTROL</td>
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Mechanical In-Exsufflation Devices

Added Code

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<tr>
<td>A7020</td>
<td>INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY</td>
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Miscellaneous

Added Code

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<td>A4566</td>
<td>SHOULDER SLING OR VEST DESIGN, ABDUCTION RESTRAINER, WITH OR WITHOUT SWATHE CONTROL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT (Note: Non-covered; No benefit category)</td>
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<tr>
<td>A9273</td>
<td>HOT WATER BOTTLE</td>
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<tr>
<td>J7686</td>
<td>TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG</td>
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Narrative Changes

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<th>New Narrative</th>
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<tr>
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<td>SHOULDER ORTHOSIS, SHOULDER CAP DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
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<tr>
<td>L3677</td>
<td>SHOULDER ORTHOSIS, HARD PLASTIC, SHOULDER STABILIZER, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>SHOULDER ORTHOSIS, SHOULDER JOINT DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
</tr>
</tbody>
</table>

Discontinued Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
<th>Crosswalk to Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0220</td>
<td>HOT WATER BOTTLE</td>
<td>A9273</td>
</tr>
<tr>
<td>E0230</td>
<td>ICE CAP OR COLLAR</td>
<td>A9273</td>
</tr>
<tr>
<td>E0238</td>
<td>NON-ELECTRIC HEAT PAD, MOIST</td>
<td>A9273</td>
</tr>
<tr>
<td>L3660</td>
<td>SHOULDER ORTHOSIS, FIGURE OF EIGHT DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>A4566</td>
</tr>
<tr>
<td>L3670</td>
<td>SHOULDER ORTHOSIS, ACRIMO/CLAVICULAR (CANVAS AND WEBBING TYPE), PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>A4566</td>
</tr>
<tr>
<td>L3672</td>
<td>SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3674</td>
</tr>
<tr>
<td>L3673</td>
<td>SHOULDER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, INCLUDES NONTORSION JOINT/TURNBUCKLE, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>L3674</td>
</tr>
<tr>
<td>L3675</td>
<td>SHOULDER ORTHOSIS, VEST TYPE ABDUCTION RESTRAINER, CANVAS WEBBING TYPE OR EQUAL, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT</td>
<td>A4566</td>
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</tbody>
</table>

Nebulizers

Added Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7686</td>
<td>TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG</td>
</tr>
</tbody>
</table>

Narrative Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Old Narrative</th>
<th>New Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A7013</td>
<td>FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR</td>
<td>FILTER, DISPOSABLE, USED WITH AEROSOL COMPRESSOR OR ULTRASONIC GENERATOR</td>
</tr>
</tbody>
</table>
### Ostomy Supplies
#### Narrative Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Old Narrative</th>
<th>New Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4399</td>
<td>OSTOMY IRRIGATION SUPPLY, CONE/CATHETER, INCLUDING BRUSH</td>
<td>OSTOMY IRRIGATION SUPPLY, CONE/CATHETER, WITH OR WITHOUT BRUSH</td>
</tr>
</tbody>
</table>

### Oxygen
#### Added Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0446</td>
<td>TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES (Note: Denied as not medically necessary; National Coverage Determination 20.29(C))</td>
</tr>
</tbody>
</table>

### Surgical Dressings
#### Narrative Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A6011</td>
<td>COLLAGEN BASED WOUND FILLER, GEL/PASTE, STERILE, PER GRAM OF COLLAGEN</td>
</tr>
<tr>
<td>A6248</td>
<td>HYDROGEL DRESSING, WOUND FILLER, GEL, STERILE, PER FLUID OUNCE</td>
</tr>
<tr>
<td>A6260</td>
<td>WOUND CLEANSERS, STERILE, ANY TYPE, ANY SIZE</td>
</tr>
<tr>
<td>A6261</td>
<td>WOUND FILLER, GEL/PASTE, STERILE, PER FLUID OUNCE, NOT OTHERWISE SPECIFIED</td>
</tr>
<tr>
<td>A6262</td>
<td>WOUND FILLER, DRY FORM, STERILE, PER GRAM, NOT OTHERWISE SPECIFIED</td>
</tr>
</tbody>
</table>

### Urological Supplies
#### Narrative Changes

<table>
<thead>
<tr>
<th>Code</th>
<th>Old Narrative</th>
<th>New Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>A5112</td>
<td>URINARY LEG BAG, LATEX</td>
<td>URINARY DRAINAGE BAG, LEG OR ABDOMEN, LATEX, WITH OR WITHOUT TUBE, WITH STRAPS, EACH</td>
</tr>
</tbody>
</table>

### Wheelchair Seating
#### Added Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2622</td>
<td>SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH</td>
</tr>
<tr>
<td>E2623</td>
<td>SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH</td>
</tr>
<tr>
<td>E2624</td>
<td>SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH</td>
</tr>
<tr>
<td>E2625</td>
<td>SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH</td>
</tr>
</tbody>
</table>

#### Discontinued Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>K0734</td>
<td>SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH</td>
</tr>
<tr>
<td>K0735</td>
<td>SKIN PROTECTION WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH</td>
</tr>
<tr>
<td>K0736</td>
<td>SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH LESS THAN 22 INCHES, ANY DEPTH</td>
</tr>
<tr>
<td>K0737</td>
<td>SKIN PROTECTION AND POSITIONING WHEELCHAIR SEAT CUSHION, ADJUSTABLE, WIDTH 22 INCHES OR GREATER, ANY DEPTH</td>
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</tbody>
</table>

#### Modifiers

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>AY</td>
<td>ITEM OR SERVICE FURNISHED TO AN ESRD PATIENT THAT IS NOT FOR THE TREATMENT OF ESRD</td>
</tr>
<tr>
<td>CS</td>
<td>ITEM OR SERVICE RELATED, IN WHOLE OR IN PART, TO AN ILLNESS, INJURY, OR CONDITION THAT WAS CAUSED BY OR EXACERBATED BY THE EFFECTS, DIRECT OR INDIRECT, OF THE 2010 OIL SPILL IN THE GULF OF MEXICO, INCLUDING BUT NOT LIMITED TO SUBSEQUENT CLEAN-UP ACTIVITIES</td>
</tr>
<tr>
<td>GU</td>
<td>WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, ROUTINE NOTICE</td>
</tr>
<tr>
<td>GX</td>
<td>NOTICE OF LIABILITY ISSUED, VOLUNTARY UNDER PAYER POLICY</td>
</tr>
<tr>
<td>NB</td>
<td>NEBULIZER SYSTEM, ANY TYPE, FDA-CLEARED FOR USE WITH SPECIFIC DRUG</td>
</tr>
<tr>
<td>SC</td>
<td>MEDICALLY NECESSARY SERVICE OR SUPPLY</td>
</tr>
</tbody>
</table>

#### Added Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>WAIVER OF LIABILITY STATEMENT ON FILE</td>
</tr>
</tbody>
</table>

#### Crosswalk to Code

- K0734: E2622
- K0735: E2623
- K0736: E2624
- K0737: E2625
Competitive Bidding

Durable Medical Equipment (DME) National Competitive Bidding (NCB) Implementation- Phase 11E: Remittance Advice (RA) and Medicare Summary Notice (MSN) Messages for Round One

CR 7066 instructs Medicare contractors to use specific Medicare Summary Notices (MSN), which go to beneficiaries, and Remittance Advice (RA) messages for providers/suppliers for specific circumstances when processing NCB claims. Those RA messages are the subject of this article.

Key Points of CR 7066
The following points detail the messages that providers and suppliers may receive as a result of the DME NCB implementation as discussed in CR 7066:

1. On remittance advices on claims paid for beneficiaries residing in CBA and obtaining an item from contract supplier in their CBA, you will receive the following, as appropriate:
   - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
   - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

2. When denying a claim for a beneficiary who resides in a CBA who obtains an item from a non-contract supplier that has not obtained a signed Advance Beneficiary Notice (ABN), you will receive the following:
   - 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.
   - 96 – Non-covered charge(s).
   - 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.

3. When a supplier has collected more than the 20 percent co-pay and any remaining deductible for an NCB claim, you will receive the following:
   - MA59 - Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
   - 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.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - N211 – Alert: You may not appeal this decision.

MLN Matters® Number: MM7066
Related Change Request (CR) #: 7066
Related CR Release Date: September 24, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R777OTN
Implementation Date: January 3, 2011

Provider Types Affected
Providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries who reside in Competitive Bidding Areas (CBAs).

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7066 to alert providers that Medicare contractors are required to use the appropriate remark, reason and Medicare Summary Notice (MSN) messages when processing National Competitive Bidding (NCB) claims for the Round One Rebid, as noted in the Key Points section below. Make certain your billing staffs are aware of these changes.

Background
Round One of the DMEPOS Competitive Bidding Program was implemented on July 1, 2008, in 10 competitive bidding areas, as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress enacted a temporary delay in the competitive bidding program for Round One Competitive Bidding Areas. The law required CMS to terminate the existing contracts that were awarded in Round One and re-compete the contracts in 2009. MIPPA also excluded certain DMEPOS items and areas from competitive bidding and provided an exemption to the program for hospitals that furnish certain types of DMEPOS items to their own patients.

On January 16, 2009, CMS issued an interim final regulation with comment period that incorporates changes required by the MIPPA. This rule implements certain MIPPA provisions that delay implementation of Round One of the Competitive Bidding Program and required CMS to conduct a second Round One competition (the Round One rebid) in 2009 and mandated certain changes for both the Round One rebid and subsequent rounds of the program.
4. When a claim is denied for an NCB item obtained from a non-contract supplier when the supplier has obtained an ABN, the following messages are used:

- **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.

5. When a beneficiary from a CBA travels to a different CBA and obtains an NCB item from a contract supplier in that CBA, the following messages are returned for the paid claim:

- **M112** - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
- **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.

6. When a beneficiary from a CBA travels to an area that is not designated as a CBA, the following messages accompany the paid claim:

- **M112** - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
- **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.

7. When Medicare makes payment to a non-contract supplier at the bid price on a grandfathered claim, the following messages are used:

- **M112** - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
- **M113** – Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.

8. The following messages are used when payment is made to a non-contract supplier at the fee schedule amount on a grandfathered claim for inexpensive and routinely purchased (IRP) items or capped rental base equipment:

- **M113** – Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.
- **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.

9. When claims from physicians or hospitals acting as DMEPOS suppliers and there is no matching office visit found in Medicare claims history, the claims are denied using the following:

- **B15** - Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/ adjudicated.
- **M114** – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.

10. When beneficiary-submitted claims that are subject to NCB are denied, the following messages are used:

- **111** – Not covered unless the provider accepts assignment.
- **M114** – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other contact your local contractor.

- **MA13** – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- **45** – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
11. Paper claims subject to NCB are denied using the following messages:

- 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.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- N211 – Alert: You may not appeal this decision.

12. Medicare will deny claims from Skilled Nursing Facilities (SNF) when the SNF acts as a limited contract supplier, but the place of service does not indicate a SNF. In denying such claims, the following messages are used:

- 170 – Payment is denied when performed/billed by this type of provider.
- M77 – Missing/incomplete/invalid place of service.
- 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.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

13. The following messages are used by Medicare when making payments for oxygen in situations where the beneficiary does not use a grandfathered supplier, so that when the 36-month payment cap under the Deficit Reduction Act (DRA) has been reached, the cap must be increased for a total of up to 45 payments:

- 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.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

14. The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for oxygen equipment when the payment cap has been reached:

- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.

15. The following messages are used by Medicare when making payments for capped rental situations where the beneficiary does not use a grandfathered supplier, so that a total maximum of up to 25 payments will be made:

- 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.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

16. The following message is used when Medicare returns unassigned NCB claims as unprocessable:

- 111 – Not covered unless the provider accepts assignment.

17. The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for a capped rental item when the payment cap has been reached:

- B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- N370: Billing exceeds the rental months covered/approved by the payer.
- 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.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

18. Medicare uses the following messages to deny claims when a modifier required for NCB is missing from a claim line:

- 4 – The procedure code is inconsistent with the modifier use or a required modifier is missing.
- 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.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
19. Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for both the base oxygen equipment and the related oxygen contents received from a non-contract supplier when the rental period for the base oxygen equipment began on or after the start date of the Round One Rebid:

- **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.

20. Medicare uses the following messages when denying oxygen content claims from a non-contract supplier that is not the same non-contract supplier that received the 36th month base oxygen equipment rental payment, when the initial date on the Certificate of Medical Necessity (CMN) for the base oxygen equipment is prior to the start date of the Round One Rebid and the CBA-residing beneficiary is not traveling:

- **B7** – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- **N211** – Alert: You may not appeal this decision.
- **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.
- **MA13** – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

21. Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for portable oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the portable oxygen equipment prior to the start of the National Competitive Bid Round One Rebid (the portable oxygen equipment is not a grandfathered item):

- **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.

Note: For all the above situations, Medicare contractors assign a Group Code of “CO” – Contractual Obligation.

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.

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

MLN Matters® Number: MM7181
Related Change Request (CR) #: 7181
Related CR Release Date: November 5, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2088CP
Implementation Date: January 3, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7181, which provides the January 2011 quarterly update for the DMEPOS competitive bidding single payment amounts. CR 7181 also provides necessary changes to Healthcare Common Procedure Coding System (HCPCS) codes and ZIP codes for the competitive bidding program. The single payment rates for the Round One Rebid of the DMEPOS competitive bidding program are implemented through CR 7181 and are effective January 1, 2011. Be sure billing staff are aware of these changes.

Background
The Medicare DMEPOS competitive bidding program was mandated by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The program’s objectives include:

- Assuring beneficiary access to quality DMEPOS items;
- Reducing the amount Medicare pays for DMEPOS items; and
- Reducing the financial burden on beneficiaries by reducing the coinsurance they pay for DMEPOS items.

The Round One Rebid Competitive Bidding Program will be 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.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBAs only, Support Surfaces (Group 2 Mattresses and Overlays). 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://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

Key Points of 7181

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)

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

The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round 1 rebid in 2009 can also be found at http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website. Further information on the boundaries and list of zip codes for each CBA and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting http://www.cms.gov/DMEPOSCompetitiveBid/01_overview.asp on the CMS website and following the link to the Competitive Bidding Implementation Contractor (CBIC).

To review Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception you may go to http://www.cms.gov/mlnmattersarticles/downloads/mm6677.pdf on the CMS website.

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

MLN Matters® Number: MM7181
Related Change Request (CR) #: 7181
Related CR Release Date: November 5, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R2088CP
Implementation Date: January 3, 2011

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

Provider Action Needed
This article is based on Change Request (CR) 7181, which provides the January 2011 quarterly update for the DMEPOS competitive bidding single payment amounts. CR 7181 also provides necessary changes to Healthcare Common Procedure Coding System (HCPCS) codes and ZIP codes for the competitive bidding program. The single payment rates for the Round One Rebid of the DMEPOS competitive bidding program are implemented through CR 7181 and are effective January 1, 2011. Be sure billing staff are aware of these changes.

Background
The Medicare DMEPOS competitive bidding program was mandated by the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. The program’s objectives include:

- Assuring beneficiary access to quality DMEPOS items;
- Reducing the amount Medicare pays for DMEPOS items; and
- Reducing the financial burden on beneficiaries by reducing the coinsurance they pay for DMEPOS items.

The Round One Rebid Competitive Bidding Program will be 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.

The Round One Rebid competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Group 2 Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices, and Related Supplies and Accessories; Hospital Beds and Related Accessories; Walkers and Related Accessories; and, in the Miami-Fort Lauderdale-Pompano Beach CBAs only, Support Surfaces (Group 2 Mattresses and Overlays). 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://www.dmecompetitivebid.com/palmetto/cbic.nsf on the Internet.

Key Points of 7181

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

HPCPCS Code Changes

The following HCPCS codes are changing from "K" codes to "E" codes in the HCPCS file, effective January 1, 2011:

- K0734 is crosswalked to E2622
- K0735 is crosswalked to E2623
- K0736 is crosswalked to E2624
- K0737 is crosswalked to E2625

This change to "E" codes for the aforementioned codes will be reflected in the competitive bidding files and public use files as part of this update.

Instructions for Competitive Bidding Modifiers

HPCPCS modifiers were developed to facilitate implementation of various policies that apply to certain competitive bidding items. The HPCPCS modifiers used in conjunction with claims for items subject to competitive bidding, along with their corresponding effective dates are:

- KG – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 1; effective 7/1/2007
- KK – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 2; effective 7/1/2007
- KU – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3; effective 7/1/2007

The KG, KK, KU, KW, and KY modifiers are modifiers that suppliers must use on claims for beneficiaries residing in CBAs to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories. All suppliers, including grandfathered suppliers, should submit claims for competitive bid items using the aforementioned competitive bidding modifiers. The KG and KK modifiers are treated as pricing modifiers in the Round One Rebid of the competitive bidding program and the KU, KW and KY modifiers are reserved for future program use.

Suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258, and A4259) furnished on or after July 1, 2007 (See the MLN Matters article related to CR5641 at http://www.cms.gov/MLNMattersArticles/downloads/MM5641.pdf on the CMS website.) Effective January 1, 2009, the KL modifier changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers should use the KL modifiers on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary’s residence and are obtained from local supplier storefronts. Contract suppliers must use the KL modifier on all claims for the diabetic supply codes identified above that are furnished via mail order.

The KV modifier is to be used to identify claims for items subject to the exceptions provided in regulations at 42 CFR 414.404(b) for certain competitive bid items that can be furnished by physicians and other practitioners who are not contract suppliers in a competitive bidding area. **Physicians and treating practitioners who are not contract suppliers** and who furnish walkers and related accessories to beneficiaries residing in a CBA must submit the informational KV modifier with claims for items/HCPCS codes in competitive bidding product category 9 (Walkers and Related Accessories), that are appropriately furnished in accordance with this exception to receive payment for these items at the applicable single payment amount. Physicians and practitioners located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries residing in a CBA must also affix the KV modifier to claims submitted for these items.

Public Use Files

Public Use Files

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

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- KU – DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3; effective 7/1/2007

The KG, KK, KU, KW, and KY modifiers are modifiers that suppliers must use on claims for beneficiaries residing in CBAs to identify when the same supply or accessory HCPCS code is furnished in multiple competitive bidding product categories. All suppliers, including grandfathered suppliers, should submit claims for competitive bid items using the aforementioned competitive bidding modifiers. The KG and KK modifiers are treated as pricing modifiers in the Round One Rebid of the competitive bidding program and the KU, KW and KY modifiers are reserved for future program use.

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The KV modifier is to be used to identify claims for items subject to the exceptions provided in regulations at 42 CFR 414.404(b) for certain competitive bid items that can be furnished by physicians and other practitioners who are not contract suppliers in a competitive bidding area. **Physicians and treating practitioners who are not contract suppliers** and who furnish walkers and related accessories to beneficiaries residing in a CBA must submit the informational KV modifier with claims for items/HCPCS codes in competitive bidding product category 9 (Walkers and Related Accessories), that are appropriately furnished in accordance with this exception to receive payment for these items at the applicable single payment amount. Physicians and practitioners located outside a CBA who furnish walkers and/or related accessories as part of a professional service to traveling beneficiaries residing in a CBA must also affix the KV modifier to claims submitted for these items.
The KV modifier should not be used by contract suppliers for competitive bidding product category 9, Walkers & Related Accessories, when submitting competitive bidding claims for this category.

Suppliers should submit claims with the KT modifier for non-mail order DMEPOS competitive bidding items that are furnished to beneficiaries that have traveled outside of the CBA in which they reside. This travel modifier must be affixed to competitive bidding claims submitted by non-contract suppliers for traveling beneficiaries residing in CBAs and by contract suppliers in CBAs that are different from the CBA where the traveling beneficiary resides.

Physicians and treating practitioners that are located outside a CBA who furnish walkers and/or related accessories in competitive bidding product category 9 as part of a professional service to traveling beneficiaries must affix the KT modifier, in addition to the KV modifier, to claims submitted for these items.

Non-contract Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) that are not located in a CBA should also use the KT modifier on claims for residents with a permanent home address in a CBA. SNF or NF claims that meet the above requirement 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 should submit mail-order diabetic supply claims for traveling beneficiaries using the beneficiary's permanent home address.

The J4 modifier is used under the DMEPOS Competitive Bidding Program to denote certain competitively bid items that a hospital can furnish to their patients on the date of discharge without submitting a bid and being awarded a competitive bidding contract. The DME items that a hospital may furnish as part of this exception are limited to: crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps. For the Competitive Bidding Program Round One Rebid, the DME competitive bid items that a hospital may furnish as part of this exception are limited to walkers and related accessories. For additional information on this exception, please see (See the MLN Matters® article related to CR 6677 at http://www.cms.gov/MLNMattersArticles/downloads/MM6677.pdf on the CMS website). Hospitals located outside a CBA, who provide walkers and/or related accessories on the date of discharge to traveling beneficiaries residing in a CBA, must also affix the J4 modifier to claims submitted for these items. The J4 modifier should not be used by contract suppliers for the Walkers and Related Accessories competitive bidding product category when submitting competitive bidding claims for this category.

The KE modifier (Bid Under Round One of the DMEPOS Competitive Bidding Program for Use With Non-Competitive Bid Base Equipment) was added to the HCPCS file effective January 1, 2009 as a pricing modifier that suppliers must use on all Part B Fee-For-Service claims to identify when the same accessory item can be furnished in multiple DMEPOS Competitive Bidding Program and non-Competitive Bidding Program product categories. For additional information on the use of the KE modifier, please refer to the instructions contained in the MLN Matters® article related to CR 6270 at http://www.cms.gov/MLNMattersArticles/downloads/MM6270.pdf on the CMS website. For beneficiaries residing in competitive bid areas, suppliers should not use the KE modifier to identify competitively bid accessories used with competitively bid base equipment. Rather, such claims should be submitted using the appropriate KG or KK modifier.

The competitive bidding modifiers should be used with the specific, appropriate competitive bidding HCPCS code when one is available. The competitive bidding HCPCS codes and their corresponding competitive bidding modifiers are denoted in the single payment amount public use charts found under the supplier page on the CBIC website: http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf on the Internet.

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.

**Reminders Regarding the Single Payment Amount**

Under the competitive bidding program, single payment amounts replace the current DMEPOS fee schedule payment amounts for competitive bidding items 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 the 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 amounts for rented enteral nutrition infusion pumps described by HCPCS code B9000 and B9002, made in accordance with section 40.3 of Chapter 20 of the Medicare Claims Processing Manual. That manual information is available at http://www.cms.gov/Manuals/Downloads/Manuals/Downloads/MLNProducts/downloads/CallCenterTollNumDirectory.zip 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

The official instruction, CR 7181 issued to your RHHI and DME MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/Downloads/R2088CP.pdf on the CMS website.

If you have any questions, please contact your RHHI or DME MAC at their toll-free number, which may be found at http://www.cms.gov/. Any questions regarding this change may be viewed at http://www.cms.gov/Downloads/Clm104C20.pdf on the CMS website. The maintenance and servicing single payment amount file is the maintenance and servicing single payment amount for the infusion pump.

Claims Modifiers for Use in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

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Note: This article was revised on January 10, 2011 to clarify and add language regarding the use of modifier KY. 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.
Each is found in both the Seat Upholstery, Replacement Only, Wheelchair Accessory, bid items. For example, HCPCS code E0981 can be used to describe both competitively and non-competitively the same supply or accessory.

HCPCS code is furnished in multiple The KG, KK, KU, and KW modifiers are modifiers that identify when related accessories to travelling beneficiaries who live in a CBA must use the appropriate KG or KK modifier. 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.

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 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](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. The following HCPCS codes are the codes for which use of the KY modifier is authorized:

- Hospital Beds and Related Accessaries jv E0271, E0272, E0280, and E0310; and
- Walkers and Related Accessories jv 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/Palmetto/Cbic.nsf/docsCat/Suppliers 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 should not be used by contract suppliers. 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.

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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.

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).
**DME MAC Jurisdiction C INSIDER**

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 (K0898). 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](http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf) on the CBIC website.

Below 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:

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<th>Accessory Code E0950 used with a</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>
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<tr>
<td>Complex Rehabilitative Group 2 Power Wheelchair (K0835 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 K0864)</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 with information for non-contract suppliers and referral agents, including fact sheets on the hospital and physician exceptions, enteral nutrition, mail order diabetic supplies, and traveling beneficiaries, as well as 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](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](http://www.cms.gov/DMEPOSCompetitiveBid) on the Centers for Medicare & Medicaid Services (CMS) dedicated website.


**Beneficiary-related information can be found at [http://www.medicare.gov](http://www.medicare.gov) on the Internet.**

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**PECOS**

**Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers’ Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)**

**MLN Matters Number:** MM6421 Revised  
**Related Change Request (CR) #:** 6421  
**Related CR Release Date:** 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 January 12, 2011, to clarify 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 give providers ample notice before claim rejections begin. Recent revisions to CR 6421 required DME MACs to delay rejecting claims until receiving further direction from CMS. Some language in this article was also revised to be more aligned with language in the Change Request.

**Provider Types Affected**

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

**Provider Action Needed**

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

**Background**

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

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

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

**Key Points**

- **During Phase 1 (October 5, 2009- 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](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. (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](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/ICN903764.pdf](http://www.cms.gov/MLNProducts/downloads/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](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule that will change how Medicare pays for dialysis services for Medicare beneficiaries who have end-stage renal disease (ESRD). CMS also issued a proposed rule that would establish a new quality incentive program (QIP) to promote high quality services in dialysis facilities by linking a facility’s payments to performance standards. The QIP is the first pay-for-performance program in a Medicare fee-for-service payment system. For additional information please see the CMS.

Medicare Fee-For-Service (FFS) and its business associates will implement the ASC X12, version 5010, and 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, clearninghouses and billing services to schedule testing with their local MAC as soon as possible. Medicare also encourages you to stay current on 5010/D.0 news and helpful tools by visiting http://www.cms.gov/Versions5010andD0/ on its website. Test early, Test often!

Get Your Flu Vaccine - Not the Flu. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. This year’s vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Health care workers, who may spread the flu to high risk patients, should get vaccinated too. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare’s coverage of the influenza vaccine and its administration, as well as related educational resources for health care staff, please visit http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and http://www.cms.gov/AdultImmunizations on the CMS website.

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

The Centers for Medicare & Medicaid Services (CMS) has announced the contract suppliers for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The list of contract suppliers is now available at http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp on the CMS website. Visit the CMS website at http://www.cms.gov/DMEPOSCompetitiveBid to view additional information on the Round 1 Rebid.

Section 6409(a) of the Affordable Care Act requires the Secretary of the Department of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, to establish a Medicare self-referral disclosure protocol ("SRDP") that sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of Section 1877 of the Social Security Act (the Act). The SRDP requires health care providers of services or suppliers to submit all information necessary for CMS, on behalf of the Secretary, to analyze the actual or potential violation of Section 1877 of the Act. Section 6409(b) of the ACA, gives the Secretary of HHS the authority to reduce the amount due and owing for violations of Section 1877. The SRDP is located at http://www.cms.gov/PhysicianSelfReferral/ on the CMS website.

Each Office Visit is an Opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. Don’t forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare’s coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf and http://www.cms.gov/AdultImmunizations on the CMS website.

The Provider Enrollment, Chain and Ownership System (PECOS) is now available for DMEPOS suppliers. DMEPOS suppliers can use Internet-based PECOS to enroll, make a change in their enrollment record, view their Medicare enrollment information on file with Medicare, and check on the status of a Medicare enrollment application via the Internet. For more information about Internet-based PECOS, including contact information for the External User Services (EUS) Help Desk, go to [http://www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll) and select the “Internet-based PECOS” tab on the left side of screen. The EUS Help Desk provides assistance to providers and suppliers if they encounter an application navigation or systems problem with Internet-based PECOS.


Remember: ICD-10 Compliance Date for Implementation - October 1, 2013 – Compliance date for implementation of ICD-10-CM (diagnoses) and ICD-10-PCS (procedures) - Only ICD-10-CM, not ICD-10-PCS, will affect physicians. ICD-10-PCS will only be implemented for facility inpatient reporting of procedures – it will not be used for physician reporting. There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. You should continue to use these codes for physician, outpatient, and ambulatory services. Physician claims for services provided to inpatient patients will continue to report CPT and HCPCS codes. For more information about ICD-10 Implementation, please read MLN Matters® Special Edition article SE1019 located at [http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf](http://www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf) on the CMS website.

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

<table>
<thead>
<tr>
<th>Contact for</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI – Electronic Claim Submission; Electronic Remittance Notices</td>
<td>Jurisdiction C CEDI (toll-free): 1.866.311.9184 (8:00a - 6:00p CST, Mon. – Fri.) Jurisdiction C CEDI website: <a href="http://www.ngscedi.com">http://www.ngscedi.com</a> E-mail: <a href="mailto:ngsc.EDIHelpdesk@wellpoint.com">ngsc.EDIHelpdesk@wellpoint.com</a></td>
</tr>
<tr>
<td>Paper Claim Submission</td>
<td>Address: CIGNA Government Services PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td>Provider Customer Service Calls</td>
<td>IVR (Interactive Voice Response): 1.866.238.9650 (Mon.-Fri., 7:00a - 9:00p CST; Sat., 6:00a - 4:00p CST) Customer Service: 1.866.270.4909 (Mon.-Fri., 7:00a - 9:00p CST) Hearing Impaired: 1.888.204.3771 (Mon.-Fri., 7:00a - 9:00p CST)</td>
</tr>
<tr>
<td>Beneficiary Customer Service Calls</td>
<td>Phone: 1.800.Medicare</td>
</tr>
<tr>
<td>Written Inquiries</td>
<td>Address: CIGNA Government Services PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td>Claim Reopenings (Adjustments)</td>
<td>Address: CIGNA Government Services PO Box 20010, Nashville, TN 37202 Fax: 1.615.782.4649 Telephone requests for Reopenings: 1.866.813.7878 (8:00a - 10:30a and 12:00p – 3:30p CST)</td>
</tr>
<tr>
<td>Claim Status Inquiry &amp; Beneficiary Eligibility</td>
<td>Security Access Issues/Password Reset, Email: <a href="mailto:MedicareOPID@cigna.com">MedicareOPID@cigna.com</a> Enrollment Status: 1.866.270.4909</td>
</tr>
<tr>
<td>Appeals – Redetermination Requests</td>
<td>Address: CIGNA Government Services PO Box 20009, Nashville, TN 37202 Fax: 1.615.782.4630</td>
</tr>
<tr>
<td>Electronic Funds Transfer</td>
<td>Address: CIGNA Government Services Attn: EFT-DME PO Box 20010, Nashville, TN 37202</td>
</tr>
<tr>
<td>Refunds</td>
<td>Address: CIGNA Government Services DME MAC Jurisdiction C PO Box 30629, New York, NY 10087-0629 Phone: 1.888.315.6930</td>
</tr>
<tr>
<td>Overnight or Special Shipping</td>
<td>Address: CIGNA Government Services DME MAC Jurisdiction C Two Vantage Way, Nashville, TN 37228</td>
</tr>
<tr>
<td>DME MAC Jurisdiction C website</td>
<td>Website: <a href="http://www.cignagovernmentservices.com">http://www.cignagovernmentservices.com</a></td>
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<tr>
<td>Advance Determination of Medicare Coverage (ADMC) - Requests</td>
<td>Address: CIGNA Government Services Attn: ADMC PO Box 20010, Nashville, TN 37202 Fax: 1.615.782.4647</td>
</tr>
<tr>
<td>Supplier Enrollment</td>
<td>Address: National Supplier Clearinghouse Palmetto GBA * AG-495 PO Box 100142, Columbia, SC 29202-3142 Phone: 1.866.238.9652</td>
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