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

New Documentation Section in LCDs

In the coming months you will see changes in many of the local coverage determinations (LCDs) and related Policy Articles (PAs) published by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs). Most of the changes represent existing requirements from the Centers for Medicare and Medicaid Services (CMS) Program Integrity Manual and DME MAC Supplier Manual. These changes serve to consolidate relevant guidance from CMS and the DME MACs on claim submission requirements such as orders, refills and proof of delivery. In addition, the DME MACs included information on continued use and continued need for items of durable medical equipment, prosthetics, orthotics and supplies.

The new language will be inserted into all DME MAC LCDs and PAs over the coming months, starting first with LCDs that require updates due to healthcare common procedure coding system (HCPCS) changes for 2012. The remainder of the LCDs will have the new language inserted during routine policy updates. Until all policies can be updated, a bulletin article summarizing the changes will also be published by each DME MAC. I encourage all providers to read the revised LCDs and related PAs carefully to ensure that claims are documented and submitted accurately.

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

Coverage & Billing

Microprocessor-Controlled Knee Systems—Correct Coding and Billing

Recent claim reviews note that suppliers are billing miscellaneous code L5999 (lower extremity prosthesis, not otherwise classified) for various elements of microprocessor-controlled knee systems such as the Otto Bock C-Leg®, C-Leg Compact™, or Genium™. This use of miscellaneous codes is not correct. For example, functions performed by the on-board microprocessors and/or sensors (e.g., “real-time gait assessment,” “electronically controlled static stance regulator, adjustable”), or programming necessary for use, must not be billed using L5999. Use of additional codes is limited to those specified below. There is no separate billing and reimbursement for any other features or functions since the allowance for all functions and features is included in the payment for codes listed below.

Base code L5856

The following are the only HCPCS codes billable for C-Leg®, Genium™ or any similar microprocessor controlled knee systems:
Advance Determination of Medicare Coverage (ADMC) - Group 4 Power Wheelchairs Removed

Advance Determination of Medicare Coverage (ADMC) is a process by which the DME MAC provides the supplier and beneficiary with a decision regarding the medical necessity for the item billed prior to submission of the claim and delivery of the product. Effective for ADMC request dates on or after January 1, 2012 the wheelchairs eligible for ADMC have changed.

Because of the February 2011 elimination of Least Costly Medically Appropriate Alternative, ADMC eligibility for Group 4 Power Wheelchairs (PWC) is eliminated. According to the local coverage determination (LCD) for Power Mobility Devices, Group 4 PWC is considered not reasonable and necessary; therefore, no ADMC is possible for this category of PWC.

Group 4 PWC are often provided as an upgrade to a covered Group 2 or 3 PWC. The ADMC request should be submitted based upon the covered PWC base

**The following wheelchairs are eligible for ADMC:**

**Manual wheelchairs**
- E1161, K0005, and K0009
- E1231-E1234

**Power wheelchairs**
- Group 2 (K0835-K0843)
- Group 3 (K0856-K0864)
- Group 3 (K0848-K0855) provided with an alternative drive control interface (E2321-E2322, E2325, E2327-E2330)
- Group 5 (K0890, K0891)

The Power Mobility LCD will be updated in a future revision.


**Safety Equipment Packages with Power Operated Vehicles (POVs)—Correct Coding**

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) received questions regarding correct coding and billing of POVs (K0800 - K0808, K0812), specifically the basic safety equipment that is considered included in the initial issue of a POV.

The Power Mobility Device local coverage determination (LCD) and related policy article (PA) detail the basic equipment package included with initial issue for a POV. The PA states:

POV Basic Equipment Package - Each POV is to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue):
- Battery or batteries required for operation
- Battery charger, single mode
- Weight appropriate upholstery and seating system
- Tiller steering
- Non-expandable controller with proportional response to input
- Complete set of tires
- All accessories needed for safe operation

All accessories necessary for the safe operation of the POV are included in the reimbursement at the time of initial issue. This includes such items as safety belts, anti-tipper devices and braking mechanisms. There is no separate billing of these items even if the supplier incurs a separate charge for the items from the manufacturer. Claims for these items, when billed separately at initial issue, will be denied for unbundling.

**Wheelchairs Eligible for Advance Determination of Medicare Coverage (ADMC)**

Wheelchairs Eligible for Advance Determination of Medicare Coverage (ADMC) - Group 4 Power Wheelchairs Removed

- L5828 - addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
- L5845 - addition, endoskeletal knee-shin system, stance flexion feature, adjustable
- L5848 - addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability
- L5856 - addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type

**Base code L5858**

The following are the only HCPCS codes billable for C-Leg Compact™ or any similar microprocessor controlled knee systems:
- L5828 - addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
- L5845 - addition, endoskeletal knee-shin system, stance flexion feature, adjustable
- L5858 - addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type

For any of the above microprocessor controlled knee systems: HCPCS code L5930 (addition, endoskeletal system, high activity knee control frame) may only be used with K4 functional level patients. Do not bill separately at initial issue miscellaneous code L5999 for the pylon with sensor for use with microprocessor controlled knee systems. It is considered included in the payment for L5856 and L5858.


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For correct coding all POVs (K0800-K0808, K0812) must have all components listed in the POV Basic Equipment Package.


**Articulating Digit(s) and Prosthetic Hands—Correct Coding**

Two new codes were released by the Centers for Medicare & Medicaid Services as part of the HCPCS 2012 Annual Release. These codes are effective for dates of service on or after January 1, 2012. The new codes are:

- L6715 TERMINAL DEVICE, MULTIPLE ARTICULATING DIGIT, INCLUDES MOTOR(S), INITIAL ISSUE OR REPLACEMENT
- L6880 ELECTRIC HAND, SWITCH OR MYOELECTRIC CONTROLLED, INDEPENDENTLY ARTICULATING DIGITS, ANY GRASP PATTERN OR COMBINATION OF GRASP PATTERNS, INCLUDES MOTOR(S).

HCPCS code L6715 describes multiple articulating digit(s) (fingers and/or thumb) which are used on initial issue when paired with a partial hand base procedure code (L6000, L6010, L6020). The articulating digit(s) can also be used as a “replacement digit(s)” with the use of the RB modifier as part of a prosthetic repair. The following base procedure codes include a custom fabricated socket.

- L6000 PARTIAL HAND, THUMB REMAINING
- L6010 PARTIAL HAND, LITTLE AND/OR RING FINGER REMAINING
- L6020 PARTIAL HAND, NO FINGER REMAINING

HCPCS Code L6025 (TRANSCARPAL/METACARPAL OR PARTIAL HAND DISARTICULATION PROSTHESIS, EXTERNAL POWER, SELF-SUSPENDED, INNER SOCKET WITH REMOVABLE FOREARM SECTION, ELECTRODES AND CABLES, TWO BATTERIES, CHARGER, MYOELECTRIC CONTROL OF TERMINAL DEVICE) describes a complete prosthesis. This base procedure code includes all necessary components. This base procedure code includes a custom fabricated socket. The use of L6715 on initial issue will be denied as unbundling.

HCPCS code L6880 describes a complete hand prosthesis, which consists of the terminal device, all articulating digits and motors. This base procedure code does not include a custom fabricated socket. This base procedure code includes all necessary components. The use of L6715 on initial issue will be denied as unbundling.

HCPCS code L7499 (UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED) must not be used for the billing of any additional features or components, programming, adjustment, etc. with L6025 or L6880 as these codes are considered all-inclusive. The use of L7499 on initial issue will be denied as unbundling.

For questions about correct coding, contact the PDAC Contact Center at 1.877.735.1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: [https://www.dmepdac.com/](https://www.dmepdac.com/)

**Ankle Foot Orthoses—Coding Guidelines**

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and the Pricing, Data Analysis and Coding (PDAC) contractor received questions regarding coding guidelines for Ankle Foot Orthoses. In an effort to address these questions, the following definitions for certain orthoses will clarify their meaning and assist suppliers in correct coding of these devices.

**L2340 ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL**

A pre-tibial shell, custom fabricated, provides a rigid overlapping interlocking anterior tibial control between the tibial tuberosity to a point no greater than 3 inches proximal to the medial malleolus. The pre-tibial shell can be constructed from thermosetting materials, thermoplastics, or composite type materials.

**L1906 ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT**

A multiligamentous ankle support provides control of the ankle joint between the medial and lateral malleoli while allowing for dorsiflexion and plantar flexion. This off-the-shelf ankle support includes a rigid stirrup and foot plate which provides functional tracking of the ankle with hind-foot and mid-foot stability during ambulation. This, in conjunction with wrap-around straps and the inherent gauntlet design, offers areas of multiligamentous support as described by the code. There are no additional HCPCS codes for this type of prefabricated ankle orthosis.

**L1960 ANKLE FOOT ORTHOSIS, POSTERIOR SOLID ANKLE, PLASTIC, CUSTOM-FABRICATED**

An Ankle Foot Orthosis (AFO) provides ankle control for patients with musculoskeletal or neuromuscular dysfunction. The AFO is designed to provide rigid immobilization of the ankle-foot complex in the sagittal, coronal, and transverse planes. The custom fabricated solid ankle AFO can be constructed from thermosetting materials, thermoplastics, or composite type materials. The proximal boarder of an Ankle Foot Orthosis (L1960) shall extend to a height no greater than 1.5 inches distal to the apex of the head of the fibula.

Effective for claims with dates of service on or after April 1, 2012, the only products which may be billed to Medicare using code L1906 (ANKLE FOOT ORTHOSIS, MULTILIGAMENTOUS ANKLE SUPPORT, PREFABRICATED, INCLUDES FITTING AND ADJUSTMENT) are those for which a written coding verification has been made by the PDAC contractor and that are listed in the Product Classification Matrix of the DME Coding System (DMECS).
DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless “there has been furnished such information as may be necessary in order to determine the amounts due such provider.” It is expected that the beneficiary’s medical records will reflect the need for the care provided. The beneficiary’s medical records include the physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

PRESCRIPTION (ORDER) REQUIREMENTS

GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary’s name
- Prescribing Physician’s name
- Date of the order and the start date, if the start date is different from the date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

DETAILED WRITTEN ORDERS (PIM 5.2.3)

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary’s name
- Physician’s name
- Date of the order and the start date, if start date is different from the date of the order

Standard Documentation Language for Local Coverage Determinations

Many errors reported in DME MAC MR Reviews and CERT Audits arise from problems associated with submitted documentation. Discussions about documentation issues commonly focus on inadequate medical record information not created by the billing supplier. However, in addition to medical record information related errors, numerous errors are identified due to noncompliance with non-medical record documents. These errors can often be avoided by the supplier. LCDs are being revised to include more detailed information about documentation requirements.

An expanded and standardized DOCUMENTATION REQUIREMENTS section has been developed. It is written in a modular format to allow each policy to contain information relevant to that policy while not including material that does not apply. This revised section includes considerable detailed information about existing Medicare requirements that has historically been found in the DME MAC Supplier Manual or in CMS interpretive manuals. Suppliers are strongly encouraged to review this material and use it to ensure that the records created will meet the standards required to justify payment for the DMEPOS item(s) provided.

This article provides a complete listing of all of the documentation requirement modules. All modules may not be used in every LCD. For example, the CMN sections would not be included in the DOCUMENTATION REQUIREMENTS section of an LCD for an item that does not require a CMN.

***IMPORTANT***

Many policies contain coverage and documentation requirements that are unique to that specific policy. Such unique information is not included in this article. It is important that suppliers review the actual LCD to be sure to have all of the relevant information necessary applicable to the item(s) provided.

In several places you will see “placeholders” like “XXX” or “###”. Information specific to the policy will be inserted in these spots.

maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search. Products which have not received coding verification review from the PDAC must be billed with code A9270.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com/.

This information will be added to a future revision of the AFO LCD and related policy article.
For items provided on a periodic basis, including drugs, the written order must include:
- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the “Date of the order” described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

The detailed description in the written order may be either a narrative description or a brand name/model number.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.

WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.4) (OPTIONAL)
A detailed written order prior to delivery (WOPD) is required for XXX. The supplier must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

MEDICAL RECORD INFORMATION

GENERAL (PIM 5.7 -5.9)
The Indications and Limitations of Coverage and/or Medical Necessity section of this LCD contains numerous reasonable and necessary (R&N) requirements. The Nonmedical Necessity Coverage and Payment Rules section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:
- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician’s office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

CONTINUED USE
Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

1. Timely documentation in the beneficiary’s medical record showing usage of the item, related option/accessories and supplies.
2. Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements. This is deemed to be sufficient to document continued use for the base item, as well.
3. Supplier records documenting beneficiary confirmation of continued use of a rental item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

CONTINUED MEDICAL NEED
For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary’s medical record must have been created prior to, or at the time of, the initial DOS to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision
of the item(s) and/or supplies, there must be information in the beneficiary’s medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

1. A recent order by the treating physician for refills
2. A recent change in prescription
3. A properly completed CMN or DIF with an appropriate length of need specified
4. Timely documentation in the beneficiary’s medical record showing usage of the item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

REFILL DOCUMENTATION (PIM 5.2.5-6) (OPTIONAL)
A routine refill prescription is not needed. A new prescription is needed when:

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

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

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

- Beneficiary’s name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Information documenting that the beneficiary’s remaining supply is approaching exhaustion by the expected delivery date

PROOF OF DELIVERY (PIM 4.26, 5.8)
Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as “Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary.”

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. There are three methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service
3. Delivery of items to a nursing facility on behalf of the beneficiary

Method 1—Direct Delivery to the Beneficiary by the Supplier
Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery slip. The POD record must include:

- Beneficiary’s name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary
If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier’s own detailed shipping invoice and the delivery service’s tracking information. The supplier’s record must be linked to the delivery service record by some clear method like the delivery service’s package identification number or supplier’s invoice number for the package sent to the beneficiary. The POD record must include:

- Date of refill request
- A description of each item that is being requested
- Date delivered
- Information documenting that the beneficiary’s remaining supply is approaching exhaustion by the expected delivery date
- Beneficiary’s name or authorized representative if different than the beneficiary
- State law requires a prescription renewal
- Beneficiary’s name or authorized representative if different than the beneficiary


- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records.
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD record must contain the information specified above.

Method 3—Delivery to Nursing Facility on Behalf of a Beneficiary

When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

Regardless the method of delivery, for those beneficiaries that are residents of a nursing facility, information from the nursing facility showing that the item(s) delivered for the beneficiary’s use were actually provided to and used by the beneficiary must be available upon request.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

GENERAL

Certificate of Medical Necessity (PIM 5.3) (OPTIONAL)

A Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for XXX is CMS Form ### (DME form ###). In addition to the order information that the physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the physician can enter the other details directly.

(Add specific DIF instructions as needed)

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

DME Information Form (PIM 5.3) (OPTIONAL)

A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

(Add specific DIF instructions as needed)

Repair/Replacement (BPM Ch 15, §100.2)

Documentation Section

A new Certificate of Medical Necessity (CMN) and/or physician’s order is not needed for repairs.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time.

A physician’s order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

Refer to the specific LCD and DME MAC Supplier manual for additional information about documentation.

Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010

MLN Matters® Number: MM6792 Revised

Related Change Request (CR) #: 6792

Related CR Release Date: February 5, 2010

Effective Date: July 1, 2010

Related CR Transmittal #: R635OTN

Implementation Date: July 6, 2010

Note: This article was revised on November 18, 2011, to correct two dates in the example provided at the top of page 3. All other information remains the same.

Provider Types Affected

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

What You Need to Know

CR 6792, from which this article is taken, announces instructions regarding payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010. Please see the Background section, below, for details.

Background

Section 1834(a)(5)(F)(ii)(III) of the Social Security Act provides for the payment of charges for reasonable and necessary maintenance of, and servicing of, oxygen equipment that you furnish after the 36-month rental payment cap for parts and labor that are not covered by the supplier’s or manufacturer’s warranty.

CR 6716, titled Continuation of Maintenance and Servicing Payments in CY 2010 for Certain Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and released November 2, 2009, provides
instructions relating to the maintenance and servicing payments for oxygen equipment furnished through June 30, 2010. (You can find the related MLN Matters® Article at http://www.cms.hhs.gov/mlnmattersarticles/downloads/MM6716.pdf on the Centers for Medicare & Medicaid Services (CMS) website.)

CR 6792, from which this article is taken, is a one-time notification that announces instructions regarding the payment for maintenance and servicing of oxygen equipment furnished for dates of service on or after July 1, 2010.

Specifically, CR 6792 provides that (effective for oxygen equipment, other than stationary or portable gaseous or liquid oxygen equipment, furnished on or after July 1, 2010) a maintenance and servicing fee of $66 is paid every 6 months, either beginning: 1) 6 months after the 36th paid rental month; or 2) when the item is no longer covered under the supplier’s or manufacturer’s warranty (whichever is later).

The maintenance and servicing fee, which will be updated annually through program instructions that are based on the covered item update for DME, covers all maintenance and servicing through the following 6 months that are needed in order to keep the oxygen equipment in good working order.

A single payment ($66 for dates of service July 1, 2010 through December 31, 2010) is made per beneficiary regardless of:

- The number of pieces of equipment serviced (stationary concentrator, portable concentrator, and/or transfilling equipment);
- When the maintenance and servicing is performed during each 6-month period; or
- How often the equipment must be maintained and serviced.

You must make at least one maintenance/servicing visit to inspect the equipment and provide any maintenance and servicing needed at the time of the visit during the first month of each 6-month period. For example:

- 36th monthly payment amount made for month ending June 30, 2010;
- 6-month period with no payment ends December 31, 2010;
- Maintenance and servicing payment may begin on January 1, 2011, provided warranty coverage ended on June 30, 2010, or earlier;
  - You must make at least one in-home visit during January 2011; and
  - Payment covers all maintenance and servicing through June 30, 2011.
- Second maintenance and servicing payment may be made on July 1, 2011;
  - You must make at least one in-home visit during July 2011, and
  - Payment covers all maintenance and servicing through December 31, 2011.

Note: You will not receive payment for maintenance and servicing of gaseous or liquid oxygen equipment (stationary or portable), or for maintenance and servicing of beneficiary-owned oxygen equipment.

Billing Guidance
You should use:

- Healthcare Common Procedure Coding System (HCPCS) codes E1390, E1391, E0433, or K0738 along with the MS modifier to bill and receive payment for maintenance and servicing of oxygen equipment other than gaseous or liquid oxygen equipment;
- HCPCS code E1390 for maintenance and servicing for a beneficiary using a single delivery port stationary oxygen concentrator or portable concentrator, and for maintenance and servicing for beneficiaries renting a combination of single delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code E1391 for maintenance and servicing for a beneficiary using a dual delivery port stationary oxygen concentrator or for beneficiaries renting a combination of dual delivery port stationary oxygen concentrators and gaseous or liquid oxygen transfilling equipment;
- HCPCS code K0738 only in situations in which the beneficiary owns stationary oxygen equipment, but rents gaseous oxygen transfilling equipment; and
- HCPCS code E0433 only in situations in which the beneficiary owns stationary equipment but rents liquid oxygen transfilling equipment.

Note: 1) Use HCPCS code E1390 (and not E1392) for maintenance and servicing of portable oxygen concentrator equipment; and 2) Bill the appropriate HCPCS code for the equipment or combination of equipment, as applicable, with the “MS” modifier.

You should remember that only one maintenance and servicing payment can be made for any combination of oxygen equipment used by the beneficiary that is classified under HCPCS codes E1390, E1391, E1392, E0433 or K0738.

For example, if maintenance and servicing is billed for a column I code/modifier, additional payment for the maintenance and servicing of any of the column II codes/modifiers will not be made.

<table>
<thead>
<tr>
<th>Column I</th>
<th>Column II</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1390MS</td>
<td>E1391MS, K0738MS, E0433MS</td>
</tr>
<tr>
<td>E1391MS</td>
<td>E1390MS, K0738MS, E0433MS</td>
</tr>
<tr>
<td>K0738MS</td>
<td>E1390MS, E1391MS, E0433MS</td>
</tr>
<tr>
<td>E0433MS</td>
<td>E1390MS, E1391MS, K0738MS</td>
</tr>
</tbody>
</table>

Further, the maintenance and servicing payments following the 36th month rental cap for oxygen concentrators and transfilling equipment terminate if the stationary oxygen equipment is replaced and a new 36-month rental period commences.

Finally, be aware that your RHHI, MAC, or DME MAC will deny your claims for the maintenance and servicing of beneficiary-owned oxygen equipment or equipment that you bill with HCPCS codes E0424, E0439, E0431, E0434, E1405, E1392 or E1406 and the “MS” modifier. They will also deny claims for more than one payment per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by
the beneficiary, for any 6-month period for either HCPCS code E1390, E1391, E0433, or K0738, billed with the “MS” modifier.

When denying such claims, they will:

- Use the following remittance advice reason and remark codes:
  - Reason code A1: Claim/Service denied;
  - Remark Code M6 (revised) – Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.
  - Remark Code N372: Only reasonable and necessary maintenance/service charges are covered.
- Assign group code CO (contractual obligation); and
- Use the following Medicare Summary Notice (MSN) messages for denied claims:
  - 8.28 - Maintenance, servicing, replacement, or repair of this item is not covered;
  - 16.35: You do not have to pay for this amount.

Additional Information

You can find more information about the maintenance and servicing payments for certain oxygen equipment after July 1, 2010 by going to CR 6792, located at http://www.cms.hhs.gov/Transmittals/downloads/R635OTN.pdf on the CMS website.

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

December 2011

Durable Medical Equipment - Documenting Continued Use

Dear Physician,

Treating physicians’ records often omit documentation of a beneficiary’s continuing use of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). By Medicare statute, lack of physician documentation regarding a beneficiary’s continued need and use of an item of DMEPOS will result in claim denials.

Many “model charts” from various clinical organizations recommend maintenance of a medication list that indicates the medication(s), strength, dosing schedule, and what the patient is actually taking. At each visit, the date of the visit is recorded and notations made regarding the patient’s adherence with each medication. In addition to the patient’s current medications, items of DME can also be incorporated into the list. Hospital beds, respiratory equipment (e.g., nebulizers, CPAP, oxygen) and diabetes testing equipment and supplies are just some of the types of DME that can be monitored through this use of an “expanded” medication list.

In the event of a record request from the medical equipment supplier, this Equipment/Medication List can be provided along with office notes to support your patient’s claim for Medicare coverage.

Thank you for your cooperation and your care of Medicare beneficiaries.

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

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

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

Richard W. Whitten, MD, MBA, FACP
Medical Director, DME MAC, Jurisdiction D

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CPS Administrators, LLC is a Medicare Part A, B, Home Health and Hospice, and DME Medicare Administrative Contractor for the Centers for Medicare & Medicaid Services.
Dear Physician,

As the Zone 5 Zone Program Integrity Contractor (ZPIC), AdvanceMed Corporation, LLC performs benefit integrity activities aimed to reduce fraud, waste, and abuse in the Medicare (Part A, B, DME, Home Health and Hospice) Program. Provider/supplier education is part of the ZPIC activities. Zone 5 will use this letter to highlight the responsibilities of the referring/ordering physician. (This a companion document to Dr. Hoover’s Jurisdiction C DME MAC’s “Dear Physician” letter that reviews the general documentation requirements for referring/ordering physicians. Dr. Hoover’s letter reiterates that referring/ordering physicians cannot charge the billing provider/supplier or the beneficiary for the required documentation. Dr. Hoover’s letter is found here: http://www.cgsmedicare.com/jc/forms/pdf/JC_Physician_Documentation_Request_Letter.pdf)

Title XVIII §1833(q) of the Social Security Act requires the referring/ordering physician information be submitted on a Medicare claim when the billing provider/supplier has received a referral or order for the referred/ordered service(s) or item.1 Section 1842 (p)(4) of the Act requires the referring/ordering physician provide documentation to the billing provider/supplier based on a referral/order:

In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Pursuant to 42 Code of Federal Regulations (CFR) § 424.535, a referring/ordering physician’s failure to provide the above required documentation may result in the revocation of enrollment and billing privileges in the Medicare program:

(a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(10) Failure to document or provide CMS access to documentation. (i) The provider or supplier (as described in section 1866(j) of the Act) did not comply with the documentation or CMS access requirements specified in §424.516(f) of this subpart.

Regulation 42 CFR § 424.516 sets forth the types of documentation that are required to be provided by impacted provider/suppliers:

Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program. (f) Maintaining and providing

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1 The definition of physician is found at http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm#act-1861-r.

“This correspondence contains data and/or information that are protected under the Privacy Act and/or the Health Insurance Portability and Accountability Act of 1996. The improper use or disclosure of this confidential and protected information may result in criminal and/or civil sanctions.”
access to documentation. (1) A provider or a supplier who furnishes covered ordered DMEPOS or referred home health, laboratory, imaging, or specialist services is required to maintain documentation for 7 years from the date of service and, upon the request of CMS or a Medicare contractor, to provide access to that documentation. The documentation includes written and electronic documents (including the NPI of the physician who ordered the home health services and the NPI of the physician or the eligible professional who ordered or referred the DMEPOS, laboratory, imaging, or specialist services) relating to written orders and requests for payments for items of DMEPOS and home health, laboratory, imaging, and specialist services.

(2) A physician who ordered home health services and a physician and an eligible professional who ordered or referred items of DMEPOS or laboratory, imaging, and specialist services is required to maintain documentation for 7 years from the date of the order, certification, or referral and, upon request of CMS or a Medicare contractor, to provide access to that documentation. The documentation includes written and electronic documents (including the NPI of the physician who ordered the home health services and the NPI of the physician or the eligible professional who ordered or referred the DMEPOS, laboratory, imaging, or specialist services) relating to written orders or requests for payments for items of DMEPOS and home health, laboratory, imaging, and specialist services.

Also, the Office of the Inspector General (OIG) U.S. Department of Health and Human Services provides physician educational resources on physician relationships with payers and vendors. These resources are found here: http://oig.hhs.gov/compliance/physician-education/index.asp. The educational information discusses maintaining and providing documentation as well as the importance of legitimate prescriptions for patients.

As a referring/ordering physician you may not ask and/or require providers/suppliers or beneficiaries to pay for or refuse to provide documentation when requested. As a referring/ordering physician, if you are asked to sign or write prescriptions for Medicare beneficiaries by a provider/supplier for unnecessary services/items or for patients you do not know, please report the incident.

To report potential Medicare fraud and abuse please review the OIG or Stop Medicare Fraud websites for multiple ways to report:

http://www.stopmedicarefraud.gov/index.html

You can also call the OIG Hotline at 1-800-HHS-TIPS (1-800-447-8477).

Working with the DMEPOS supplier increases the level of care your patient(s) receive as well as ensures only services and/or items that are legitimately prescribed by you are provided to your patient(s).

Sincerely,

Zone 5 ZPIC
As the Zone 5 Zone Program Integrity Contractor (ZPIC), AdvanceMed Corporation, LLC performs benefit integrity activities aimed to reduce fraud, waste, and abuse in the Medicare (Part A, B, DME, Home Health and Hospice) Program. Provider/supplier education is part of the ZPIC activities. In this educational article Zone 5 will highlight the responsibilities of the referring/ordering physician.

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Jurisdiction C DME MAC’s Medical Director, Robert D. Hoover, published a “Dear Physician” letter that reviews the general documentation requirements for referring/ordering physicians. Dr. Hoover’s letter reiterates the above information as well as reminds referring/ordering physicians that they cannot charge the billing provider/supplier or the beneficiary for the required documentation. Dr. Hoover’s letter is found here:


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As a billing provider/supplier, if you are asked and/or required to pay for or refused documentation by a referring/ordering physician, please report the incident as potential fraud and/or abuse. As a referring/ordering physician, if you are asked to sign or write prescriptions for Medicare beneficiaries by a provider/supplier for unnecessary services/items or for patients you do not know, please report the incident.

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You can also call the OIG Hotline at 1-800-HHS-TIPS (1-800-447-8477).
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 December 21, 2011, to clarify the cost report language for low volume facility adjustments on page 6. All other information remains 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,

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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:

The ESRD PPS 4-year Transition Period Blended Rate Determination

<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 0.53711.

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

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

The ESRD PRICER will provide the payment for existing composite rate, 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:
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 cost report 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 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.

**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.

**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](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.

You may also want to review the following articles:

- MLN Matters® article MM7476 ([http://www.cms.gov/MLNMattersArticles/downloads/MM7476.pdf](http://www.cms.gov/MLNMattersArticles/downloads/MM7476.pdf)), which alerts providers to changes to Attachments 4, 5 and 8 of CR7064; and
- MM7497 ([http://www.cms.gov/MLNMattersArticles/downloads/MM7497.pdf](http://www.cms.gov/MLNMattersArticles/downloads/MM7497.pdf)), which informs independent laboratories (ILs) that effective January 1, 2012, CMS has eliminated the requirement for ILs to bill separately for each individual AMCC laboratory test included in organ disease panel codes for ESRD eligible beneficiaries. It states that organ disease panels will be paid under the Clinical Laboratory Fee Schedule and will not be subject to the 50/50 rule when billed by ILs.

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

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

**MLN Matters® Number:** MM7397 *Revised*

**Related Change Request (CR) #:** 7397

**Related CR Release Date:** December 15, 2011

**Effective Date:** January 1, 2013

**Related CR Transmittal #:** R2368CP

**Implementation Date:** January 1, 2013

*Note:* This article was revised on December 16, 2011, to reflect the revised CR7397 issued on December 15. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the Web address for accessing CR7397 were revised. All other information remains the same.

**Provider Types Affected**

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

**What You Should Know**

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

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

**Background**

**Pharmacies billing drugs**

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

- Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.
- In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician’s service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

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

**When drugs may not be billed by pharmacies to Medicare Part B**

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

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

**Payment limits**

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

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

**Additional Information**

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

The following manual sections regarding billing drugs and biological and “incident to” services may be helpful:


**Medical Policy**

**Automatic External Defibrillators (AED) Draft Local Coverage Determination - Update**

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) released a draft revision of the AED LCD for comment on August 4, 2011, with the comment period ending on September 23, 2011. The DME MAC medical directors appreciate the feedback from all commenters on the draft policy. Based upon the comments received, the DME MAC medical directors will make no changes to the current policy at this time.

**Electronic Data Interchange (EDI)**

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

MLN Matters® Number: MM7683  
Related Change Request (CR) #: CR 7683  
Related CR Release Date: December 22, 2011  
Effective Date: April 1, 2012  
Related CR Transmittal #: R3372CP  
Implementation Date: April 2, 2012

**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.

**Provider Action Needed**

**STOP – Impact to You**

This article is based on Change Request (CR) 7683 which updates Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Medicare Remit Easy Print (MREP), and PC Print for Medicare.

**CAUTION – What You Need to Know**

Change Request (CR) 7683 instructs Medicare contractors and the Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software. Be sure your billing staff is aware of these changes.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

**Background**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice transaction. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, appropriate Group Code must be reported as well. Additionally, for transaction 837 COB, CARC must be used.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website) if they are currently being used. In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before
The actual “Stop Date” posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update Change Request (CR) will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR7683, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only 3 times a year and may not match the CMS release schedule.

CR7683 lists only the changes that have been approved since the last code update CR (CR 7514 Transmittal 2304), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule (see above for exception).

The WPC website (at http://www.wpc-edi.com/Reference on the Internet) has four listings available for both CARC and RARC:

1. **All**: All codes including deactivated and to be deactivated codes are included in this listing.
2. **To Be Deactivated**: Only codes to be deactivated at a future date are included in this listing.
3. **Deactivated**: Only codes with prior deactivation effective date are included in this listing.
4. **Current**: Only currently valid codes are included in this listing.

Note: In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare.

Claim Adjustment Reason Codes (CARCs):
A national code maintenance committee maintains the health care. The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see http://www.wpc-edi.com/Reference on the Internet.

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier than a future date. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule.

The following new Claim Adjustment Reason Codes were approved by the Code Committee in October, and must be implemented, if appropriate, by April 2, 2012.

### New Codes – CARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>238</td>
<td>Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR).</td>
<td>3/1/2012</td>
</tr>
<tr>
<td>239</td>
<td>Claim spans eligible and ineligible periods of coverage. Rebill separate claims (use Group Code OA).</td>
<td>3/1/2012</td>
</tr>
</tbody>
</table>

### Modified Codes – CARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Modified Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Exact duplicate claim/service (Use with Group Code OA).</td>
<td>1/1/2013</td>
</tr>
</tbody>
</table>

### Deactivated Codes – CARC:

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Narrative</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>141</td>
<td>Claim spans eligible and ineligible periods of coverage.</td>
<td>7/1/2012</td>
</tr>
</tbody>
</table>

Remittance Advice Remark Codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized

**CHECK IT OUT!**

The CGS DME MAC Jurisdiction C Provider Outreach & Education page on Facebook®
Become a fan and get all of the latest DME MAC Provider Outreach & Education (POE) information and more on the CGS DME POE page on Facebook® at: http://www.facebook.com/cignagovernmentsservices
maintainer of RARCs receives requests from Medicare and non-Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change.

CR7683 contains no new, modified, or deactivated RARC codes.

Additional Information
The official instruction, CR7683, 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/R2372CP.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.

Additional Health Insurance Portability and Accountability Act (HIPAA) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process

MLN Matters® Number: SE1137 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 January 17, 2012, to add a section to clarify Medicare’s capability to cross over HIPAA Version 4010A1 or National Council for Prescription Drug Programs (NCPDP) Version 5.1 batch claims to the Coordination of Benefits Agreement (COBA) supplemental payers that have cut-over to exclusive receipt of claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats. It also clarifies the crossover impact for the providers that are permitted to submit claims using the CMS 1500 or UB04 hardcopy formats. All other information remains unchanged.

Provider Types Affected
This MLN Matters® Special Edition (SE) Article is intended to alert physicians, providers, and suppliers who bill Medicare contractors (Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What Providers Need to Know
Supplemental payers are transitioning to HIPAA 5010 or NCPDP D.0 under the National Crossover Process. Currently, the Centers for Medicare & Medicaid Services (CMS) is transitioning supplemental payers that participate in the national COBA crossover process from their production Version 4010A1, HIPAA 837 claims to HIPAA Versions 5010A1 and 5010A2 837 claims. As COBA supplemental payers move into production on the 5010A1 and A2 claim formats, CMS requires that they continue to accept their “pre–HIPAA 5010” production Version 4010A1 claims for 14 full calendar days after their cut-over to the new claim formats.

The following is an example to further illustrate this point:

Payer A moved to HIPAA 5010 production on November 7, 2011. Medicare will then systematically transfer to Payer A all “clean” electronically received 4010A1 claims that are already on the payment floor and tagged for crossover as of November 3 and 4, 2011. Beginning with claims that CMS’ Coordination of Benefits Contractor (COBC) received that have a file date of November 22, 2011, Medicare, through the COBC, will no longer be able to transfer production 4010A1 claims to payer A. This is because 14 full calendar days have elapsed since Payer A moved into production on the HIPAA 5010 claim formats.

Note: The same premise will hold for inbound Version 5.1 batch NCPDP claims when a supplemental payer moves into production on the NCPDP D.0, Version 5.2 batch format for receipt of crossover claims.

As provided in CMS Change Requests (CRs) 6658* and 6664*, the COBC activates the following edits once COBA trading partners move into HIPAA 5010 or NCPDP D.0 production:

- N22226—“4010A1 production claim received, but the COBA trading partner is not accepting 4010A1 production claims.”
- N22230—“NCPDP 5.1 production claim received, but the COBA trading partner is not accepting NCPDP 5.1 production claims.”

*To review the entire CR6658, visit http://www.cms.gov/transmittals/downloads/R1844CP.pdf on the CMS website.
*To review the entire CR6664, visit http://www.cms.gov/transmittals/downloads/R1841CP.pdf on the CMS website.

Providers, physicians, and suppliers should note that they will see the foregoing edit codes on the special provider notification letters that Medicare mails to them at their on-file correspondence address when Medicare is unable to send various claims for crossover purposes. Receipt of these codes on the special provider notification letters denotes that:

1. The patient’s supplemental payer has moved into HIPAA 5010 or NCPDP D.0 production receipt for all Medicare crossover claims; and
2. For a limited timeframe (likely 30 days after a supplemental payer cuts over to Version 5010 for crossover claims receipt), providers, physicians, and suppliers will need to file the affected claims directly with their patients’ supplemental payers.

Key Points
- Your Medicare contractor will not attempt to repair claims that the COBC returns via the COBC Error Reports with error codes N22226 through N22229, regardless of error percentage.
- Your Medicare contractor will create special provider letters to their affiliate suppliers in association with “production” claims that the COBC rejects with error code N22226 or N22228. Per CMS instruction, these letters indicate that Medicare cannot cross the listed patient-specific claims over to patient’s supplemental payer and include a specific “222” error code and accompanying description. MLN Matters®
Article MM3709 details the initial CMS instructions to contractors and may be reviewed at http://www.cms.gov/MLNMattersArticles/downloads/MM3709.pdf on the CMS website.

- Complete details of the COBA Error Notification process are included in the official instruction issued to your Medicare contractor and may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R474CP.pdf on the CMS website.
- Be aware of the claims not being crossed over automatically and take appropriate action to obtain payments from the supplemental payer/insurer.

Additional Clarification of the Crossover Claims Process

There is some confusion in the provider community concerning whether billing of hardcopy CMS 1500 or UB04 claims or HIPAA Version 4010A1 or NCPDP Version 5.1 batch claims to Medicare will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the Version 5010 837 claim formats or NCPDP D.0 batch claim formats.

In other words, there is an assumption being made that billing vendors or physician/practitioner, provider, or supplier offices that bill Medicare will continue to receive error code N22226 for every occasion that they bill claims to Medicare using a hardcopy (paper) claim format (CMS-1500 or UB-04) or Version 4010A1 or NCPDP 5.1 batch formats. This assumption is incorrect, as explained below.

During the 90 day non-enforcement period (January 1, 2012—March 31, 2012), Medicare has the systematic capability to convert incoming claim formats in accordance with external supplemental payer specifications concerning production claims format. That is, Medicare will have the ability to:

- Take incoming claims submitted by the provider community in hardcopy (paper) format or Version 4010A1 or NCPDP 5.1 batch claim formats and convert them to HIPAA Version 5010A1 or 5010A2 claim formats, as appropriate, or NCPDP D.0 batch claim formats for those COBA supplemental payers that already have cut-over to exclusive receipt of Version 5010 COB claims in production; and
- Take incoming claims submitted by the provider community in the Version 5010A1 or 5010A2 or NCPDP D.0 batch claim formats and convert them to HIPAA Version 4010A1 claim formats or NCPDP 5.1 COB batch claim format for those supplemental payers that have not cut-over to production use of the HIPAA Version 5010 COB claim formats or NCPDP D.0 batch claim format.

This action is controlled by information that Medicare’s Common Working File (CWF) receives concerning individual supplemental payers’ ability to accept HIPAA 5010 or NCPDP D.0 claim formats in “production” mode. With the exception of incoming hardcopy claims, this practice will discontinue at the conclusion of the 90 day non-enforcement period.

Additional Information

If you have any questions about Electronic Data Interchange (EDI) Medicare, customers may call their regional EDI Helpline to access information. These regional toll free numbers may be found in the “Downloads” section of the Electronic Billing & EDI Transactions web page at http://www.cms.gov/ElectronicBillingEDITrans/ on the CMS website.

Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims

This MLN Matters® Special Edition Article is intended for all physicians, providers, and suppliers who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Home Health and Hospice MACs (HH+H MACs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

The Office of E-Health Standards and Services (OESS) announced on November 17, 2011, that although the 5010/D.0
compliance date of January 1, 2012 will not change, HIPAA enforcement of compliance with the standards will be deferred until March 31, 2012.

The 5010 versions of the institutional and professional claim implementation guides mandate that when claims use non-specific procedure codes a corresponding description of the service is now required.

Please make certain your billing and coding staff follow these requirements for submitting a HIPAA compliant claim when Non-Specific Procedure codes are used. Please ensure these implementation guide requirements are followed when submitting a HIPAA compliant claim for all Non-Specific Procedure codes.

**Background**

The HIPAA Version 5010 implementation guide describes Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: “Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name”. If a procedure code containing any of these descriptor terms is billed, a corresponding description of that procedure is required; otherwise, the claim is not HIPAA compliant. Note that there is no crosswalk of non-specified procedure codes with corresponding descriptions.

Detailed information regarding this new requirement can be found in the 837I and 837P implementation guides (837I – 005010X223A2 and 837P – 005010X222A1). If the corresponding non-specific procedure code description is not submitted, the transaction does not comply with the implementation guide and is not, therefore, HIPAA compliant.

**Additional Information**


If you are not ready, consider contacting your Medicare contractor to receive the free Version 5010 software (PC-Ace Pro32) and begin testing now. Or, consider contracting with a Version 5010 compliant clearinghouse who can translate the non-compliant transactions into compliant 5010 transactions.

If you are billing Part B and DME claims, you may download the free Medicare Remit Easy Print (MRREP) software to view and print compliant HIPAA 5010 835 remittance advice from their A/B MACs website.

Contact your respective professional associations and other payers for guidance and resources in order to meet their deadlines.

Please note, Change Request (CR) 7392, “Common Edits and Enhancements Module (CEM) and Receipt, Control, and Balancing Updates,” dated July 21, 2011, established the requirements that all procedures shall comply with the HIPAA 5010 version claim process. CR7392 was implemented by Medicare contractors on October 1, 2011, and does not override any previous claims processing instructions.

### Miscellaneous

**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:** October 14, 2011  
**Effective Dates:** Phase 1 – October 1, 2009  
**Related CR Transmittal #:** R963OTN  
**Implementation Date:** Phase 1 – October 5, 2009  
**Phase 2 – To be announced**

**Note:** This article was to reflect a revised CR6421. The CR was revised to delete chiropractors from the list of providers on page 2 who may order and/or refer. As a result, the CR release date transmittal number and Web address for accessing the CR were revised. Also remember that the Centers for Medicare & Medicaid Services has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a PECOS record. CMS will give providers ample notice before claim rejections begin. Please note, the implementation and effective dates in this article are different than what is in the related CR. The “To Be Announced” implementation and effective dates in this article are the correct dates.

**Provider Types Affected**

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

**Provider Action Needed**

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

Background

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

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

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider on the claim and unique identifier of the ordering/referring provider on the claim.

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 not of the type/specialty to order or refer, the claim will also continue to process.
- 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.
- If the DMEPOS supplier claim is a paper CMS-1500 claim, the DMEPOS supplier will see the rejection indicated on the Remittance Advice.
- I don’t have an enrollment record. What should I do? Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see “Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners” at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on the CMS website.

Additional Information

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

The official instruction, CR6421, issued to your Medicare DME MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R963OTN.pdf on the CMS website.
Recovery Audit Program: Medicare Administrative Contractor (MAC)-issued Demand Letters

MLN Matters® Number: MM7436 Revised
Related Change Request (CR) #: 7436
Related CR Release Date: January 6, 2012
Effective Date: January 3, 2012
Related CR Transmittal #: R202FM
Implementation Date: January 3, 2012

Note: This article was revised on January 9, 2012, to reflect the revised CR7436 issued on January 6, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR7436 were revised. All other information is the same.

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

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

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

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

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

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

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

To see the official instruction (CR7436) issued to your Medicare contractor, see http://www.cms.gov/Transmittals/downloads/R202FM.pdf on the CMS website.

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

MLN Matters® Number: MM7499 Revised
Related Change Request (CR) #: CR 7499
Related CR Release Date: August 5, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R993OTN
Implementation Date: January 3, 2012 for professional claims billed to carriers or B MACs; April 2, 2012 for institutional claims billed to Fiscal intermediaries or A MACs; October 9, 2012 for supplier claims submitted to DME MACs

Note: This article was revised on November 7, 2011, to reflect changes made to CR7499. In this article, the implementation dates (see above), the CR release date, transmittal number, and the Web address for accessing CR7499 were revised. All other information is the same.

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

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

Background
The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA) as a response to provider request per CR6870 and

It has been brought to the attention of CMS that providing the Patient Control Number as received on the original claim rather than the Health Insurance Claim (HIC) number would:
- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

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

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

**Additional Information**

The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R993OTN.pdf](http://www.cms.gov/Transmittals/downloads/R993OTN.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](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

**Update to Medicare Deductible, Coinsurance, and Premium Rates for 2012**

**MLN Matters® Number:** MM7567 *Revised*

**Related Change Request (CR) #:** CR 7567

**Related CR Release Date:** December 16, 2011

**Effective Date:** January 3, 2012

**Related CR Transmittal #:** R74GI

**Implementation Date:** January 3, 2012

**Note:** This article was revised on December 19, 2011, to reflect a revised CR7567 issued on December 16, 2011. In the article, the CR release date, transmittal number, and the Web address for accessing CR7567 were revised. All other information is the same.

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), A/B Medicare

Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 7567, which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2012. Be sure billing staffs are aware of these updates.

**Background**

**2012 Part A - Hospital Insurance (HI)**

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. 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 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 **2012 inpatient deductible is $1,156.00.** The coinsurance amounts are shown below in the following table:

<table>
<thead>
<tr>
<th>Hospital Coinsurance</th>
<th>Skilled Nursing Facility Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days 61-90</td>
<td>Days 91-150 (Lifetime Reserve Days)</td>
</tr>
<tr>
<td>$289.00</td>
<td>$578.00</td>
</tr>
<tr>
<td>Days 21-100</td>
<td></td>
</tr>
<tr>
<td>$144.50</td>
<td></td>
</tr>
</tbody>
</table>

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person’s initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2012 Part A premiums are as follows:

<table>
<thead>
<tr>
<th>Voluntary Enrollees Part A Premium Schedule for 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Premium (BP)</td>
</tr>
<tr>
<td>$451.00 per month</td>
</tr>
<tr>
<td>Base Premium with 10% Surcharge</td>
</tr>
<tr>
<td>$496.10 per month</td>
</tr>
<tr>
<td>Base Premium with 45% Reduction</td>
</tr>
<tr>
<td>$248.00 per month (for those who have 30-39 quarters of coverage)</td>
</tr>
<tr>
<td>Base Premium with 45% Reduction and 10% Surcharge</td>
</tr>
<tr>
<td>$272.80 per month</td>
</tr>
</tbody>
</table>
2012 Part B - Supplementary Medical Insurance (SMI)
Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

- **Standard Premium:** $99.90 a month
- **Deductible:** $140.00 a year
- **Coinsurance:** 20 percent

In addition, some beneficiaries may pay higher premiums based on their incomes. These amounts change each year. There may be a late-enrollment penalty.

### Additional Information
The official instruction, CR7567, issued to your carriers, FIs, A/B MACs, and RHHIs regarding this change may be viewed at [http://www.cms.gov/Transmittals/downloads/R74GI.pdf](http://www.cms.gov/Transmittals/downloads/R74GI.pdf) on the CMS website.

If you have any questions, please contact your carriers, FIs, A/B MACs, or RHHIs 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.

### Use of Revised Remittance Advice Remark Code (RARC) N103 When Denying Services Furnished to Federally Incarcerated Beneficiaries

**MLN Matters® Number:** MM7678  
**Related Change Request (CR) #:** 7678  
**Related CR Release Date:** January 6, 2012  
**Effective Date:** July 1, 2012  
**Related CR Transmittal #:** R1012OTN  
**Implementation Date:** July 2, 2012

#### Provider Types Affected
Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs or DME MACs) for Medicare beneficiaries who are incarcerated in a Federal facility.

#### Provider Action Needed
**STOP – Impact to You**
This article is based on Change Request (CR) 7678 which informs Medicare contractors that the Centers for Medicare & Medicaid Services (CMS) is amending Remittance Advice Remark Code (RARC) N103 to include language that further explains the newly modified RARC N103—denying claims for services to federally incarcerated beneficiaries.

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while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

Additional Information

The official instruction, CR7678, issued to your Medicare contractors (FIs, A/B MACs, DME MACs, and carriers) regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R1012OTN.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.

Preventive Services Educational Resources for Health Care Professionals

MLN Matters® Number: SE1142
Related Change Request (CR) #: NA
Related CR Release Date: NA
Effective Date: NA
Related CR Transmittal #: NA
Implementation Date: NA

Provider Types Affected

This MLN Matters® Special Edition Articles is intended for all Medicare Fee-For-Service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who order, refer, or provide Medicare-covered preventive services to Medicare beneficiaries.

What You Need to Know

- Use this article as a reference to available educational resources related to Medicare-covered preventive services.
- Make each office visit an opportunity to encourage your patients to receive preventive services for which they are eligible.

Introduction

Medicare covers a wide variety of preventive services and screenings for eligible beneficiaries.

Educational Products for Health Care Professionals

The Medicare Learning Network® (MLN) offers a variety of educational products to help you understand coverage, coding, reimbursement, and billing information related to these services.

1. MLN Preventive Services Products for Health Care Professionals

   b. Quick Reference Information: Preventive Services – This educational tool is designed to provide education on the Medicare-covered preventive services. It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf on the CMS website.
   c. Quick Reference Information: Medicare Part B Immunization Billing – This educational tool is designed to provide education on Medicare-covered preventive immunizations. It is available in print and as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS website. This product is also available in hardcopy as part of the “Quick Reference Information Resources” hardcopy booklet.
   d. Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination – This educational tool is designed to provide education on the Initial Preventive Physical Examination, also known as the IPPE. It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf on the CMS website.
   e. Quick Reference Information: The ABCs of Providing the Annual Wellness Visit – This educational tool is designed to provide education on the Annual Wellness Visit (AWV). It is available as a downloadable PDF at http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf on the CMS website.
   f. Preventive Brochures and Fact Sheets – In addition, the MLN offers the following brochures and fact sheets:

      - Annual Wellness Visit,
      - Bone Mass-Measurements,
      - Cancer Screenings,
      - Diabetes-Related Services,
      - Expanded Benefits,
      - Human Immunodeficiency Virus Screening,
      - Mass Immunizers and Roster Billing,
      - Preventive Immunizations, and
      - Tobacco-Use Cessation Counseling Services.

To view the downloadable PDFs for these products, visit the Preventive Services Educational Products PDF page at http://www.cms.gov/MLNProducts/Downloads/education_products_prevserv.pdf on the CMS website.

Note: To order hardcopy products, please visit the Preventive Services MLN Educational Products web page at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp and go to the “Related Links Inside CMS” section and select “MLN Product Ordering Page.”

MLN Preventive Services Educational Products Web Page - This MLN web page provides descriptions of all MLN preventive service-related educational products and resources designed specifically for Medicare FFS health care professionals. This web page is available at http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.
2. Other CMS Resources
   - Prevention General Information Overview web page is available at http://www.cms.gov/PreventionGenInfo on the CMS website.

3. Additional Preventive Services

Under the Affordable Care Act, CMS has the authority to cover additional preventive services that meet certain criteria through the National Coverage Determination Process. In addition to the websites above, please visit the CMS press release web page at http://www.cms.gov/apps/media/press_releases.asp on the CMS website.

Beneficiary Information

Please visit the Medicare.gov web page at http://www.medicare.gov for beneficiary-related information and resources you may share with your Medicare patients.

Fees & Pricing

Reasonable Charge Update for 2012 for Splints, Casts, and Certain Intraocular Lenses

MLN Matters® Number: MM7628
Related Change Request (CR) #: CR 7628
Related CR Release Date: November 18, 2011
Effective Date: January 3, 2012
Related CR Transmittal #: R2349CP
Implementation Date: January 3, 2012

Provider Types Affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs)) for splints, casts, and certain intraocular lenses.

What Providers Need to Know

Change Request (CR) 7628, on which this article is based, announces that payment of claims for splints, casts, and for intraocular lenses implanted in a physician’s office (codes V2630, V2631, V2632) continues to be made on a reasonable charge basis subject to certain payment limits. CR7628 also announces that the update factor for the Inflation Indexed Charge (IIC) for 2012 is 3.6 percent.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, and intraocular lenses (codes V2630, V2631, and V2632) implanted 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.

CR7628 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, and intraocular lenses furnished in Calendar Year 2012. 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 June 30, 2011. The 2012 payment limits for splints and casts will be based on the 2011 limits that were announced in CR7225 last year, increased by 3.6 percent, the percentage change in the CPI-U for the 12-month period ending June 30, 2011. (You can read the MLN Matters® article associated with CR7225 at http://www.cms.gov/MLNMattersArticles/downloads/MM7225.pdf on the Centers for Medicare & Medicaid (CMS) website.) The IIC update factor for 2012 is 3.6 percent.

A list of the 2012 payment limits for splints and casts is listed in the table that follows.

<table>
<thead>
<tr>
<th>Q-codes</th>
<th>2012 Payment Limits for Splints and Casts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4565</td>
<td>$8.12</td>
</tr>
<tr>
<td>Q4003</td>
<td>$46.21</td>
</tr>
<tr>
<td>Q4004</td>
<td>$174.65</td>
</tr>
<tr>
<td>Q4005</td>
<td>$33.19</td>
</tr>
<tr>
<td>Q4006</td>
<td>$114.91</td>
</tr>
<tr>
<td>Q4007</td>
<td>$12.24</td>
</tr>
<tr>
<td>Q4008</td>
<td>$27.58</td>
</tr>
<tr>
<td>Q4009</td>
<td>$6.13</td>
</tr>
<tr>
<td>Q4010</td>
<td>$13.79</td>
</tr>
<tr>
<td>Q4011</td>
<td>$4.08</td>
</tr>
<tr>
<td>Q4012</td>
<td>$9.20</td>
</tr>
<tr>
<td>Q4013</td>
<td>$14.88</td>
</tr>
<tr>
<td>Q4014</td>
<td>$25.08</td>
</tr>
<tr>
<td>Q4015</td>
<td>$7.44</td>
</tr>
<tr>
<td>Q4016</td>
<td>$12.54</td>
</tr>
<tr>
<td>Q4017</td>
<td>$8.60</td>
</tr>
<tr>
<td>Q4018</td>
<td>$13.71</td>
</tr>
<tr>
<td>Q4019</td>
<td>$4.31</td>
</tr>
<tr>
<td>Q4020</td>
<td>$6.86</td>
</tr>
<tr>
<td>Q4021</td>
<td>$6.36</td>
</tr>
<tr>
<td>Q4022</td>
<td>$11.48</td>
</tr>
<tr>
<td>Q4023</td>
<td>$3.20</td>
</tr>
<tr>
<td>Q4024</td>
<td>$5.74</td>
</tr>
<tr>
<td>Q4025</td>
<td>$35.68</td>
</tr>
<tr>
<td>Q4026</td>
<td>$111.41</td>
</tr>
<tr>
<td>Q4027</td>
<td>$17.85</td>
</tr>
<tr>
<td>Q4028</td>
<td>$55.72</td>
</tr>
<tr>
<td>Q4029</td>
<td>$27.29</td>
</tr>
<tr>
<td>Q4030</td>
<td>$71.83</td>
</tr>
<tr>
<td>Q4031</td>
<td>$13.64</td>
</tr>
<tr>
<td>Q4032</td>
<td>$35.91</td>
</tr>
<tr>
<td>Q4033</td>
<td>$25.45</td>
</tr>
<tr>
<td>Q4034</td>
<td>$63.30</td>
</tr>
<tr>
<td>Q4035</td>
<td>$12.72</td>
</tr>
<tr>
<td>Q4036</td>
<td>$31.66</td>
</tr>
<tr>
<td>Q4037</td>
<td>$15.53</td>
</tr>
<tr>
<td>Q4038</td>
<td>$38.90</td>
</tr>
<tr>
<td>Q4039</td>
<td>$7.78</td>
</tr>
<tr>
<td>Q4040</td>
<td>$19.44</td>
</tr>
<tr>
<td>Q4041</td>
<td>$18.88</td>
</tr>
<tr>
<td>Q4042</td>
<td>$32.23</td>
</tr>
<tr>
<td>Q4043</td>
<td>$9.45</td>
</tr>
<tr>
<td>Q4044</td>
<td>$16.12</td>
</tr>
<tr>
<td>Q4045</td>
<td>$10.96</td>
</tr>
<tr>
<td>Q4046</td>
<td>$17.63</td>
</tr>
<tr>
<td>Q4047</td>
<td>$5.47</td>
</tr>
<tr>
<td>Q4048</td>
<td>$8.82</td>
</tr>
<tr>
<td>Q4049</td>
<td>$2.00</td>
</tr>
</tbody>
</table>

Additional Information

You can find the official instruction, CR7628, issued to your carrier, FI, MAC by visiting http://www.cms.gov/Transmittals/downloads/R2349CP.pdf on the CMS website.

Detailed instructions for calculating:

1. **Reasonable charges** are located in the “Medicare Claims Processing Manual,” Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 80 (Reasonable Charges as Basis for Carrier/DMERC Payments);
2. **Customary and prevailing charges** are located in “Medicare Claims Processing Manual,” Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.2 (Updating Customary and Prevailing Charges) and 80.4 (Prevailing Charge); and
The IIC are located in "Medicare Claims Processing Manual," Chapter 23 (Fee Schedule Administration and Coding Requirements), Sections 80.6 (Inflation Indexed Charge (IIC) for Nonphysician Services).


If you have any questions, please contact your carrier, FI, 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.

**CY 2012 Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

**MLN Matters® Number:** MM7635  
**Related Change Request (CR) #:** CR 7635  
**Related CR Release Date:** November 4, 2011  
**Effective Date:** January 1, 2012  
**Related CR Transmittal #:** R2340CP  
**Implementation Date:** January 3, 2012

**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**

**STOP – Impact to You**

Updates and information in CR 7635 can impact reimbursement for your claims for DMEPOS items or services.

**CAUTION – What You Need to Know**

This article, based on Change Request (CR) 7635, advises you of the Calendar Year (CY) 2012 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.

Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2012.

**GO – What You Need to Do**

You should make sure that your billing staffs are aware of these changes.

**Background and Key Points of CR 7635**

Payment on a fee schedule basis is required for durable medical equipment, prosthetic devices, orthotics, prosthetics, and surgical dressings (DMEPOS) by Sections 1834(a), (h), and (i) of the Social Security Act (the Act); and for parenteral and enteral nutrition (PEN) by 42 CFR, Section 414.102.

In accordance with these statutes and regulations, the DMEPOS fee schedules are updated annually; and the process for this update is documented in the “Medicare Claims Processing Manual”, Chapter 23 Fee Schedule Administration and Coding Requirements, Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule at http://www.cms.gov/manuals/downloads/clm104c23.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

CR 7635, from which this article is taken, provides instructions regarding annual the DMEPOS fee schedule annual update for 2012.

**Fee Schedule Files**

The DMEPOS fee schedule file will be available on or after November 16, 2011, for State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.hhs.gov/DMEPOSFeeSched/ on the CMS website.

**HCPCS Codes Added**

The following new codes are effective as of January 1, 2012:

- A9272 which has no assigned payment category;
- A5056 and A5057 in the ostomy, tracheostomy, and urological supplies (OS) payment category;
- E0988 in the capped rental (CR) category;
- L5312, L6715, and L6880 in the prosthetics and orthotics category; and
- E2358, E2359, E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 in the inexpensive/routinely purchased (DME) payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2012 DMEPOS Fee Schedule Update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2012 through June 30, 2012. The new codes are not to be used for billing purposes until they are effective on January 1, 2012.

Please note that the HCPCS codes listed as new codes in this CR may not be final and are subject to change pending release of the CY 2012 HCPCS file.

**HCPCS Codes Deleted**

The following codes are being deleted from the HCPCS effective January 1, 2012, and are therefore being removed from the DMEPOS fee schedule files:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Category</th>
<th>Factor</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.485</td>
<td>Oxygen</td>
<td>0.621</td>
<td>Surgical Dressings</td>
</tr>
<tr>
<td>0.488</td>
<td>Capped Rental</td>
<td>0.676</td>
<td>Parenteral &amp; Enteral Nutrition</td>
</tr>
<tr>
<td>0.490</td>
<td>Prosthetics &amp; Orthotics</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
KE Modifier Update

To ensure appropriate modifier processing when submitting claims for HCPCS code E0776 (IV Pole), suppliers should bill using the following modifiers depending upon the type of pump that the IV pole is used with:

- For use with infusion pumps – submit E0776RR, E0776NU, or E0776UE;
- For use with parenteral pumps – submit E0776RRBAKE, E0776NUBAKE, or E0776UEBAKE;
- For use with enteral pumps – submit E0776RRBAK, E0776NUBAK or E0776UEBAK.

Similarly, when submitting claims for a replacement HCPCS code E2373 (POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK) suppliers should bill using the following modifiers depending upon the associated base wheelchair:

- For use with a power wheelchair HCPCS code that was bid in Round I of the DMEPOS Competitive Bidding Program – submit E2373KCRR, E2373KNU or E2373KCU;
- For use with a power wheelchair HCPCS code that was not bid in Round I of the DMEPOS Competitive Bidding Program – submit E2373KCRKE, E2373KNUKE or E2373KCUKE;
- For beneficiaries that permanently reside in Round I Rebid competitively bid areas when used with a power wheelchair HCPCS code that was bid in the Round I of the DMEPOS Competitive Bidding Program – submit E2373KCRKK, E2373KNUUK or E2373KCUKEK.

CR 7635 also announces other coding and pricing changes, effective January 1, 2012:

1. New HCPCS codes: E2626, E2627, E26268, E 2629, E2630, E2631, E2632, and E2633 (for wheelchair accessories for shoulder elbow arm supports) are re-designated from codes L3964-L3974 and the fee schedule amounts will be directly assigned from the deleted codes to the new codes.

2. The fee schedule amounts for shoe modification HCPCS codes A5503 through A5507 are being adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the original fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2012, the base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2010 and the fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change.

Note: The above billing instructions supersede the E0776 and E2373 KC billing instructions furnished in Transmittal 1630, CR6270, dated November 7, 2008.

Attachment B to CR 7635 contains a list of the HCPCS codes that were selected in 2008 for Round I of the DMEPOS Competitive Bidding Program. For beneficiaries who permanently reside in Round I Rebid competitive bid areas, a list of the Round 1 Rebid competitively bid items is available in the single payment amount charts located at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Single%20Payment%20Amounts on the Competitive Bidding Implementation Contractor (CBIC) website.

CY 2012 Fee Schedule Update Factor

For CY 2012, the update factor of 2.4 percent is applied to the applicable CY 2011 DMEPOS fee schedule amounts.

In accordance with section 1834(a)(14) of the Act, the DMEPOS fee schedule amounts are to be updated for 2012 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2011, adjusted by the change 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 MFP adjustment is 1.2 percent and the CPI-U percentage increase is 3.6 percent. Thus, the 3.6 percentage increase in the CPI-U is reduced by the 1.2 percentage increase in the MFP resulting in a net increase of 2.4 percent for the MFP-adjusted update factor.

2011 Update to Labor Payment Rates

2012 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 3.6 percent effective for dates of service on or after January 1, 2012 through December 31, 2012, and those rates are as follows:

© 2012 Copyright, CGS Administrators, LLC.
2012 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR 7635 implements the 2012 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2012. As required by statute, the payment amount must be adjusted annually, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE).

The updated national 2012 monthly payment amount of $176.06 for stationary oxygen equipment codes is included in the DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, 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.

2012 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR 7635 also updates the 2012 payment amount for maintenance and servicing for certain oxygen equipment.
HCPCS Updates

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters® Number: MM7599
Related Change Request (CR) #: 7599
Related CR Release Date: October 7, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2317CP
Implementation Date: January 3, 2012

Provider Types Affected
Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care are affected.

Provider Action Needed
This article announces that Change Request (CR) 7599 is a recurring update notification that provides the annual HH consolidated billing update, effective January 1, 2012. Make sure your billing staff is aware of these changes.

Background
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the HH Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a HH episode (i.e., under a HH plan of care administered by a home health agency). Medicare will only directly reimburse the primary HH agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., ‘K’ codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. New updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key Points
The HCPCS codes in the table below are being added to the HH consolidated billing supply code list.

<table>
<thead>
<tr>
<th>Added HCPCS Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>AS056</td>
<td>Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each.</td>
</tr>
<tr>
<td>AS057</td>
<td>Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each.</td>
</tr>
</tbody>
</table>

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


Competitive Bidding

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

MLN Matters® Number: MM7498 Revised
Related Change Request (CR) #: 7498
Related CR Release Date: December 23, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R1008OTN
Implementation Date: January 3, 2012

Note: This article was revised on December 27, 2011, to reflect a revised CR7498. In this article, the CR release date, transmittal number, effective date, and the Web address for accessing CR7498 are revised. All other information is the same.

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

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

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

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

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

Additional Information
The official instruction, CR7498 issued to your DME/ MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R1008OTN.pdf on the CMS website. If you have any questions, please contact your DME/MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

January 2012 Quarterly Update for the DMEPOS Competitive Bidding Program
MLN Matters® Number: MM7632
Related Change Request (CR) #: CR 7632
Related CR Release Date: November 4, 2011
Effective Date: January 1, 2012
Related CR Transmittal #: R2341CP
Implementation Date: January 3, 2012

Provider Types Affected
Providers and suppliers submitting claims to Medicare Durable Medical Equipment (DME) Medicare Administrative Contractors (DME MACs), or Medicare Regional Home Health Intermediaries (RHHIs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 7632 which provides the January 2012 quarterly update for the DMEPOS Competitive Bidding Program files. CR7632 contains necessary changes to the Healthcare Common Procedure Coding System (HCPCS), Competitive Bidding Area (CBA) ZIP Code, and CBA Pricing files effective January 1, 2012. Be sure billing staff are aware of these changes.
Background

Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid.

The Round One Rebid Competitive Bidding Program was implemented on January 1, 2011, in 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 CBA 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.

MIPPA requires the competition for Round Two to occur in 2011 in 70 additional metropolitan statistical areas (MSAs) and authorizes competition for national mail order items and services after 2010. The Affordable Care Act of 2010 (ACA) expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program on the CMS website at http://www.cms.gov/DMEPOSCompetitiveBid/.

Competitive Bidding ZIP Codes

For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA. ZIP codes are established by the United States Postal Service (USPS). The CBA numbers and associated names are as follows:

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

Updates to the ZIP Code Files

Six new ZIP codes have been added to the ZIP code file to conform with United States Postal Service ZIP code changes within CBAs:

<table>
<thead>
<tr>
<th>ZIP</th>
<th>CBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>75033</td>
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</tr>
<tr>
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</tr>
<tr>
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<td>33206</td>
<td>33100</td>
</tr>
<tr>
<td>33206</td>
<td>33101</td>
</tr>
</tbody>
</table>
Updates to the HCPCS and Single Payment Amount Files:
There are no updates to these files at this time.

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

Single Payment Amount
Currently, Medicare payment for most DMEPOS items is based on fee schedules in most areas of the country. However, the Social Security Act (Section 1847; see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm on the Internet) mandates that competitive bidding single payment amounts replace the current DMEPOS fee schedule payment amounts for competitively bid items in CBAs. Therefore, the single payment amount is the Medicare allowed payment amount for competitively bid items for beneficiaries who reside in the Round One Rebid CBAs. Medicare pays contract suppliers 80 percent of the single payment amount for each competitively bid item. Beneficiaries are 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. Single payment amounts remain the same throughout the term of suppliers’ contracts.

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 ACA (see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf on the Internet) 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 fee schedule amount for the first three months and 75 percent of the fee schedule 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 ACA, 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 the “Medicare Claims Processing Manual” (Chapter 20, Section 40.3; see http://www.cms.gov/Manuals/downloads/clm104c20.pdf on the CMS website). The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

Additional Information
The official instruction, CR7632, issued to your DME MACs and RHHIs regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2341CP.pdf on the CMS website.

If you have any questions, please contact your DME 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.

April 2012 Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

MLN Matters® Number: MM7638
Related Change Request (CR) #: 7638
Related CR Release Date: December 2, 2011
Effective Date: April 1, 2012
Related CR Transmittal #: R2363CP
Implementation Date: April 2, 2012

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

Provider Action Needed
This article is based on Change Request (CR) 7638, which provides the DMEPOS April 2012 quarterly update. This update implements
necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, and single payment amount files effective April 1, 2012. Be sure your billing staff is aware of these changes.

Background
Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new competitive bidding program for certain DMEPOS. Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and the Centers for Medicare & Medicaid Services (CMS) awards contracts to enough suppliers to meet beneficiary demand for the bid items. The new, lower payment amounts resulting from the competition replace the Medicare DMEPOS fee schedule amounts for the bid items in these areas. All contract suppliers must comply with Medicare enrollment rules, be licensed and accredited, and meet financial standards. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in 10 areas in 2007. As required by law, CMS conducted the Round One competition in 10 areas and for 10 DMEPOS product categories, and successfully implemented the program on July 1, 2008, for two weeks before the contracts were terminated by subsequent law.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008, terminated the Round One contracts that were in effect, and made other limited changes. As required by MIPPA, CMS conducted the supplier competition again in 2009, referring to it as the Round One Rebid.

The Round One Rebid Competitive Bidding Program was implemented on January 1, 2011, in 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 CBA 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.

MIPPA requires the competition for Round Two to occur in 2011 in 70 additional Metropolitan Statistical Areas (MSAs) and authorizes competition for national mail order items and services after 2010. The Affordable Care Act expands the number of Round Two MSAs from 70 to 91 areas and mandates that all areas of the country are subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. You can find additional information on the DMEPOS Competitive Bidding Program at http://www.cms.gov/DMEPOSCOMPETITIVEBID/ on the CMS website.

Competitive Bidding ZIP Codes
For competitive bidding, ZIP codes designated as mail order only are assigned a separate CBA number from the standard CBA. ZIP codes are established by the United States Postal Service (USPS). The CBA numbers and associated names are as follows:

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- 17461 - Cleveland-Elyria-Mentor, OH (mail order only)
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Public Use Files
The competitive bidding ZIP codes and single payment amounts per product category and CBA are available on the CBIC website for interested parties like DMEPOS suppliers, State Medicaid agencies, and managed care organizations. The CBIC website can be accessed at http://www.dmecompetitivebid.com/palmetto/cbic.nsf or by going to http://www.cms.gov/DMEPOSCOMPETITIVEBID/01_overview.asp on the 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.

**Single Payment Amount**

Currently, Medicare payment for most DMEPOS items is based on fee schedules in most areas of the country. However, the Social Security Act (Section 1847; see http://www.ssa.gov/OP_Home/ssact/title18/1847.htm on the Internet) mandates that competitive bidding single payment amounts replace the current DMEPOS fee schedule payment amounts for competitively bid items in CBAs. Therefore, the single payment amount is the Medicare allowed payment amount for competitively bid items for beneficiaries who reside in the Round One Rebid CBAs. Medicare pays contract suppliers 80 percent of the single payment amount for each competitively bid item. Beneficiaries are 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. Single payment amounts remain the same throughout the term of suppliers’ contracts.

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 (see http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf on the Internet) 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 purchase single payment amount (or fee schedule amount for grandfathered suppliers) for the first three months and 75 percent of the single payment amounts (or fee schedule amounts for grandfathered suppliers) 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 the “Medicare Claims Processing Manual” (Chapter 20, Section 40.3; see http://www.cms.gov/Manuals/downloads/clm104c20.pdf on the CMS website). The maintenance and servicing single payment amounts are equal to 5 percent of the single payment amount purchase price for the infusion pump.

**Key Points of CR7638**

**Updates to the ZIP Code Files:**

There are no updates to these files at this time

**Updates to the HCPCS and Single Payment Amount Files:**

There are no updates to these files at this time.

**Additional Information**

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

The official instruction associated with this CR7638 issued to your Medicare DME MAC or RHHI regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2363CP.pdf on the CMS website.

**News Flash Items**

Quick reference charts can be handy lists for looking up information! The Medicare Learning Network (MLN) has produced two QUICK REFERENCE CHARTS, which provide information on frequently used CMS web pages. The Quick Reference: All Medicare Providers (DEC2009) chart includes a list of CMS web pages that ALL Medicare providers use most frequently. The Quick Reference: New Medicare Provider (DEC2009) chart includes a list of CMS web pages that NEW Medicare providers use most frequently. These charts can be bookmarked and viewed online or they can be printed and used as ready references. Both charts can be located at http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp on the MLN Publications page. Use search key word “quick” to locate these publications.

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 Fact sheet (7/26) at http://www.cms.gov/apps/media/fact_sheets.asp on the CMS website.

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

Vaccinate Early to Protect Against the Flu /2011-2012 Influenza Vaccine Prices Are Now Available. CDC recommends a yearly flu vaccination as the most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Under Medicare Part B, Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And don’t forget to immunize yourself and your staff. Get the Flu Vaccination – Not the Flu. CMS has posted the 2011-2012 seasonal influenza vaccine payment limits at: http://www.cms.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the CMS website. Influenza vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related educational provider resources, visit the following CMS web pages Medicare Learning Network® Preventive Services (http://www.cms.gov/MLNProducts/35_PreventiveServices.asp) and Immunizations (http://www.cms.gov/immunizations/).

Get the Flu Vaccine -- Not the Flu. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp.

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

Want to stay connected about the latest new and revised Medicare Learning Network® (MLN) products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.cms.gov/MLNProducts/downloads/MLNProducts_listserv.pdf and start receiving updates immediately!

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

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

Podcasts from the Thursday, July 21 National Provider Call “The ABCs of the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)” are now available. Short on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smart phone. Two podcasts are now available at http://www.CMS.gov/MLNProducts/MLM/itemdetail.asp?itemID=CMS1249934 on the CMS website. The 2 audio podcasts for the IPPE and AWV with corresponding written transcripts, as well as the full audio and written transcript of the call can be accessed by scrolling to the “Downloads” section at the bottom of the page.

Per Section 5501(a) of the Affordable Care Act, the Primary Care Incentive Payment (PCIP) program authorizes an incentive payment of 10 percent of Medicare’s program payments to be...
paid to qualifying primary care physicians and non-physician practitioners for services rendered from Sunday, January 1, 2011, to Thursday, December 31, 2015. CMS has published 22 Frequently Asked Question (FAQ) items related to the PCIP program. These new FAQs can be found here. Alternatively, these FAQ items can be found by visiting http://questions.CMS.hhs.gov/ and searching for “PCIP” or “Primary Care Incentive Payment.”

Looking for the latest new and revised MLN Matters® articles? Subscribe to the MLN Matters® electronic mailing list! For more information about MLN Matters® and how to register for this service, go to http://www.cms.gov/MLN MattersArticles/downloads/What_Is_MLN Matters.pdf and start receiving updates immediately!

Protect Your Patients. Protect Your Family. Protect Yourself.
Flu seasons are unpredictable and can be severe. Each year, approximately 90 percent of seasonal flu-related deaths and more than 60 percent of seasonal flu-related hospitalizations occur in people 65 years and older. Please encourage your Medicare patients to get an annual flu shot. A flu shot is important for healthcare workers too, who may spread the flu to high risk patients. The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related educational provider resources, visit the following CMS webpages: Medicare Learning Network® Preventive Services (http://www.cms.gov/MLNProducts/35_PreventiveServices.asp) and Immunizations (http://www.cms.gov/immunizations/). Get the Flu Vaccine -- Not the Flu.

The Centers for Medicare & Medicaid Services (CMS) has announced the expansion of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program to include the Round 2 and National Mail Order competitions. If you want to bid, you need to prepare now! You must make sure that your correspondence address and your authorized officials’ names, Social Security numbers, and birth dates are accurate in your enrollment file at the National Supplier Clearinghouse (NSC) before registration starts. Before you submit a bid for a product category in a Competitive Bidding Area (CBA), you must have all required state licenses for that product category for each state in that CBA. It is VERY IMPORTANT that you make sure that current versions of all required licenses are in your enrollment file with the NSC BEFORE you bid. If any required licenses are expired or missing from your enrollment file, we can reject your bid and you can’t get a contract. For more information about the Medicare DMEPOS Competitive Bidding Program please visit the CMS DMEPOS Competitive Bidding website at http://www.cms.gov/DMEPOSCompetitiveBid/ on the CMS website.

Hurry, time is running out! HIPAA Version 5010 and D.0 will be required to submit Medicare claims beginning Sunday, January 1, 2012! As of Sunday, January 1, 2012, Version 5010 and NCPDP D.0 will be required for all HIPAA standard transactions. Beginning Sunday, January 1, 2012, HIPAA Version 4010A1 will no longer be accepted by Medicare. All trading partners must operate in HIPAA Version 5010 and D.0. CMS strongly encourages providers to take advantage of the many resources available at http://www.cms.gov/ICD10, http://www.cms.gov/ Versions5010andD0/01_overview.asp, and http://www.cms.gov/MFFS5010D0/ on our website. It is essential to begin the transition now to prevent a disruption to your claims processing and cash flow.

The publication titled “How to Search the Medicare Coverage Database” (revised April 2011), is now available in downloadable format from the Medicare Learning Network®. It was designed to provide education about how to use the Medicare Coverage Database (MCD) and includes an explanation of the database and how to use the search, indexes and reports, and download features. The booklet is available at http://www.cms.gov/MLNProducts/downloads/MedicareCoverageDatabase_ICN901346.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Special Edition Article #SE1128 (http://www.cms.gov/MLNMattersArticles/downloads/SE1128.pdf) titled “Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs),” reminds affected providers about their responsibilities to QMBs. This article is intended to help providers avoid inappropriately billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments.
## DME MAC Jurisdiction C Contact Information

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