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How to Successfully Bill for an Oxygen Denial

National Government Services, the Jurisdiction B Durable Medical Equipment Administrative Contractor (DME MAC) has received several questions regarding how to bill in order to receive an oxygen denial. In situations where suppliers are aware that the beneficiary **does not** meet the medical necessity coverage criteria as outlined in the Local Coverage Determination (LCD) for Oxygen and Oxygen Equipment (L27221). An example would be a situation in which the ordering physician has prescribed oxygen for a diagnosis unrelated to severe lung disease or hypoxia-related diagnosis (i.e., migraine headaches).

If a required blood gas study or oxygen saturation test was **not** performed, suppliers must include **"No test performed billing for denial & ICD-9 diagnosis code"** in the Note segment (NTE) of the electronic claim format or Item 19 of the CMS-1500 paper claim form.

Suppliers should also transmit with the claim an electronic Certificate of Medical Necessity (CMN) or for paper submitters a hard copy CMN, with the question set answered as follows:

1b) 99
1c) date of service of claim
2) 1
3) 1
4) D
5) 2
6) Blank
7) Y
8) N
9) N

Suppliers should execute an Advance Beneficiary Notice of Noncoverage (ABN) advising the Medicare beneficiary that Medicare will deny payment for oxygen therapy as not medically necessary due to the coverage criteria not being met. If an ABN was properly executed, modifier **GA** should be appended on the claim—this will result in the appropriate patient responsibility (PR-50) denial. You can access additional information concerning ABNs in the Jurisdiction B DME MAC Supplier Manual, Chapter 10, "Advance Beneficiary Notice of Noncoverage ."

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National Government Services is Preparing to Unveil "Connex" Web Portal in 2010

National Government Services is preparing to unveil an all-new Web portal aimed at providers/suppliers and offering access to a wide array of valuable Medicare information. This Web portal, called, "National Government Services Connex" provides beneficiary eligibility and entitlement information; queries for claims status; viewing of your provider/supplier demographic information; queries for your financial data; ordering of duplicate remittances and more.

Connex offers superior search capabilities and makes it fast and easy for you to find information without having to place calls to the National Government Services Provider Contact Center or the Interactive Voice Response (IVR). This system will be provided at no cost to you and will only require Internet access.

Currently, Connex is being tested by a selected group of providers and suppliers. Once approved, the system will be rolled out in stages and the goal is to have all National Government Services providers and suppliers access to Connex in 2010.

As more information becomes available and as the system is rolled-out to a specific line of business or geographical area, it will be announced through National Government Services listservs and Web site (www.NGSMedicare.com).

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When to update an Electronic Funds Transfer Setup

All suppliers must send in an updated Electronic Funds Transfer (EFT) form when changes are made that affect their EFT setup with National Government Services.

An updated EFT form is **required** in the following situations:

- Bank name change
- Bank account number change
- Routing number change
- Supplier information change
    - Authorized/delegated official
    - Tax Identification Number
    - National Provider Identifier
    - Medicare Identification Number (PTAN)
    - Name
    - Address

To update/change a current EFT setup, go to the National Government Services Web site, www.NGSMedicare.com:

- Select **Business Type:** Durable Medical Equipment
- Select **Region:** Jurisdiction B
- Click on the "**Go**" button
- Once on the portal page, select **Claims**, then **Electronic Data Interchange**
- Click on the **Overview of EDI Products and Services** link
- Then click the **Electronic Funds Transfer (EFT)** link

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Items Requiring Span Date

Certain durable medical equipment prosthetics, orthotics, and supplies (DMEPOS) items must be submitted with span dates according to the number of days the item or service is being rendered. When billing with span dates, the "From" date should reflect the date that the item was delivered or shipped, depending on the method of delivery (see Chapter 8, *Documentation/Interruptions in a Period of Continuous Use,* of the Jurisdiction B DME MAC Supplier Manual for date of service billing instructions). The "To" date should reflect the number of days that the quantity of dispensed supplies are expected to last. That number of days should be added to the "From" date. The "To" date will usually not be the end date of the time period that the item/service is intended to be used. For example, a 30-day quantity of supplies is delivered on June 25, 2009. They are expected to be used from July 1, 2009, until July 30, 2009. The span dates that should be billed are "From" June 25, 20099, "To" July 24, 2009. The July 24 date is 30 days after the delivery date. (Note: Different instructions apply to billing date spans for continuous passive motion devices.)

Claims with span dates of service may be submitted immediately after the "From" date and should not be held until after the "To" date. If additional supplies are needed before the end to the previous span date range, the claim can be submitted. In this situation, the "From" date of the new claim will be before the "To" date of the prior claim. When billing for refills, suppliers are encouraged to review and follow the proof of delivery guidelines set forth in the Program Integrity Manual.

Per the Program Integrity Manual, Chapter 4 §4.26.1 *Proof of Delivery and Delivery Methods*

> "For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier should deliver the DMEPOS product no sooner than approximately five days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. DME MACs shall allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply."

Note: This section of the Program Integrity Manual may be viewed in its entirety on the CMS Web site at: http://www.cms.gov/manuals/downloads/pim83c04.pdf

Suppliers are reminded that claims for DMEPOS items other than those indicated in this article should not be billed with span dates. For the other DMEPOS items, the "From" date should be the date of delivery or the shipping date and the "To" date either should be left blank or should be the same as the "From" date. For rental items, the period of service is assumed to be one month.

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The items listed below require span date billing. In the next few paragraphs we will discuss and provide examples of how to bill for each using a span date.

- Continuous passive motion device
- Diabetic testing supplies
- Parenteral and enteral nutrition

Note: This article is provided as a resource to aid DMEPOS suppliers in span date billing and should not be used as a guide to determine if a DMEPOS item is covered by Medicare. All DMEPOS suppliers are encouraged to review the local medical policies to ensure that their patient meets the Medicare coverage criteria and that all pertinent documentation requirements are met as indicated in each individual medical policy. Local medical policies are located on the National Government Services Web site at:
http://www.ngsmedicare.com/lcd.aspx?CatID=3

Continuous Passive Motion Device

Continuous passive motion (CPM) devices are covered when the device is applied within two days following a total knee replacement. Coverage for this device is limited to the portion of the three-week period following surgery during which the device is used in the patient's home. The span date instructions are different for CPM devices than they are for other items.

Key things to remember when billing for a CPM device:

- The "From" date should represent the date the beneficiary began to use the CPM device in their home.
- The "To" date must represent the date the use of the CPM device ends.
- The units of service billed should reflect the actual number of calendar days the CPM was used by the beneficiary in the home
- Additional days billed beyond the three-week coverage period will be denied as not medically necessary with ANSI code CO-151.

In addition, suppliers must provide the following information in item 19 of the paper CMS-1500 claim form or in NTE segment of the electronic version:

- State the type of surgery performed (such as "total knee replacement") or provide the current procedural terminology (CPT) code for the surgical procedure (e.g., 27447, 27486, or 27487)
- Date of the surgery
- Date the device was initiated
- Date of discharge from the hospital or nursing home (NH) (if the patient is discharged from the hospital to a skilled nursing facility [SNF] or rehabilitation center before going home, please use the discharge date when the patient went home)
- Claims submitted without the required information will receive a CO-50 (*these are non-covered services because this is not deemed a medical necessity by the payer)* denial.

A suggested format for providing this information can be submitted as follows:

- SURGERY DT 6/1/09 DT APPLIED 6/2/09 DT D/C HOME 6/5/09 CPT 27447

Example:

- Date of surgery = 06/01/2009
- Date that CPM device was applied = 06/02/2009
- Date of discharge from hospital/home use begins = 06/05/2009
- End of coverage = 06/22/2009
- Beneficiary use of device ends = 06/29/2009

Claim submission based upon above:

- From date 06/05/2009
- To date 06/29/2009
- HCPCS E0935RR
- Units of Service 25 days (25 UOS)

Medicare will cover 18 days (June 5-22). The additional days will be denied CO-151 (*payment adjusted because the payer deemed the information submitted does not support this many/frequency of services*) due to the excessive number of days beyond the three-week coverage period.

Diabetic Testing Supplies

Medicare will reimburse for blood glucose test strips (A4253) and lancets (A4259) when the patient has met the coverage criteria outlined in the local medical policy. The quantity of test strips and lancets allowed per month depends on whether or not the patient is treated with insulin injections. When billing for diabetic testing supplies, the claim must indicate whether or not the patient is insulin treated by appending the KX modifier (insulin treated) or the KS modifier (non-insulin treated) to the each claim line for the test strips and lancets. In addition to indicating whether or not the patient is insulin treated, the claim for the testing supplies must be spanned to reflect the number of days that the test strips that were dispensed are expected to last based on the frequency of testing ordered by the physician or performed by the beneficiary, whichever is less frequent.

Key things to remember when billing for diabetic testing supplies:

- The claim must indicate whether or not the patient is being treated by insulin (KX or KS modifiers)
- A beneficiary or their caregiver must specifically request refills of glucose monitor supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/shipping date. For subsequent refill deliveries, the supplier should deliver the product no sooner than approximately five days prior to the end of usage for the current product.
- The date of service for glucose test strips and lances must be spanned for complete claim adjudication. Failure to span the dates of service on a claim for glucose test strips and

lancets will result in a CO-16 (*Claim/Service lacks information needed for adjudication)* rejection
- The date span on the claim will generally not be the same as the actual dates of use by the beneficiary.
- One unit of service for test strips (A4253) is equal to 50 strips
- One unit of service for lancets (A4259) is equal to 100 lancets

Example:
- Insulin treated beneficiary testing three times per day (KX modifier)
- 90-day supply – 300 test strips (A4253) and 300 lancets (A4259) – is provided on June 1, 2009
- The 90 day period after June 1 would end on August 29, 2009

Claim submission based upon the above information:
- From date 06/01/2009
- To date 08/29/2009
- HCPCS/Modifier A4253KX
- Units of Service 6

- From date: 06/01/2009
- To date: 08/29/2009
- HCPCS/Modifier A4259KX
- Units of Service 3

Parenteral/Enteral Nutrition

No more than one month's supply of parenteral/enteral nutrients, equipment, or supplies may be dispensed at one time. Therefore, the maximum supply that can be billed at one time is a 31-day supply.

Suppliers must not automatically dispense a quantity of items on a predetermined regular basis, even if the beneficiary has "authorized" this in advance. It is the supplier's responsibility to assess how much nutrition and supplies the beneficiary is actually using by contacting the beneficiary or caregiver prior to dispensing the items. The supplier must determine the quantities that remain from the previous delivery and modify the quantity delivered or the delivery date accordingly. If the beneficiary has not used all of their previously delivered nutrients/supplies, the supplier should either delay delivery of the next shipment or should reduce the quantity delivered so that there is no more than one month's supply on hand at any one time. This may occur in situations in which the beneficiary was admitted to the hospital or in which the beneficiary did not receive their usual nutrient intake because of an acute illness, etc.

Contact with the beneficiary or designee regarding refills should take place no sooner than approximately seven days prior to the delivery/shipping date. For subsequent refill deliveries, the supplier should deliver the product no sooner than approximately five days prior to the end of usage for the current product. The Medicare system will allow up to a five-day overlap in dates of

service for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting his/her supply.

The supplier itself may deliver the parenteral/enteral nutrition and supplies directly to the beneficiary or the supplier may use a shipping service to ship the items. If the supplier delivers the items directly to the beneficiary, the "From" date of service on the claim will be the actual date the items were delivered. If the supplier ships the items to the beneficiary using a shipping service, the "From" date of service will be the date the items were shipped. To determine the "To" date of service, the supplier counts the number of days the nutrients are expected to last (ex: supplier ships a 28-day supply) and adds that number of days to the "From" date on the claim. Span dates on the claim will not usually match the dates of expected use of the nutrients.

Example (supplier used a shipping service):

- Month 1:
  - 11/2/09 – 28-day supply shipped
  - 11/4/09 - Beneficiary receives supply of nutrients
  - 11/5/09 - Beneficiary starts using nutrients
  - 12/2/09 - Beneficiary finishes supply of nutrients in this shipment
  - Dates of service on claim:
    - "From" date = 11/02/09 (date the nutrients were shipped)
    - "To" date = 11/29/09 (28 days after the from date since a 28-day supply was shipped)

Note that the span dates ("From" and "To" dates) are determined by the date the nutrients were shipped and the number of days for which the quantity shipped is expected to last. The span dates do not coincide with the dates the beneficiary actually used the nutrients.

- Month 2:
  - 11/26/09 - Supplier calls beneficiary to determine beneficiary's usage during the previous month and determines quantity of next shipment
  - 11/30/09 – 28-day supply of nutrients shipped to beneficiary (expected dates of use 12/3/09 – 12/30/09)
  - 12/2/09 – beneficiary receives shipment
  - 12/3/09 – beneficiary begins using nutrients shipped
  - 12/13/09 – 12/17/09 – beneficiary admitted to inpatient hospital stay
  - 1/4/10 – beneficiary exhausts supply
- Dates of service on claim:
  - "From" date = 11/30/09 (date the nutrients were shipped)
  - "To" date = 12/27/09 (28 days after the "From" date since a 28-day supply was shipped)

Shipping Supply Kits

Supply kits consist of multiple items which are sometimes shipped separately. As with nutrients, the span dates on the claim usually will not match the dates of expected use of the supplies.

Example (supplier uses a shipping service):

11/1/09 – 28-day supply of infusion pump bags and tubing shipped
11/8/09 – 28-day supply of irrigation syringes shipped
11/26/09 – 28-day supply of infusion pump bags and tubing shipped

Claim submission based upon above shipping example:

- Month 1:
- B4035
- 28 UOS
- "From" date: 11/1/09
- "To" date: 11/28/09

- Month 2:
  - B4035
  - 28 UOS
  - "From" date 11/26/09
  - "To" date 12/23/09

In instances where the supplies are delivered directly by the supplier, the ***date the beneficiary received the DMEPOS supply shall be the "From" date on the claim.***

If a supplier utilizes a shipping service or mail order, suppliers shall use the shipping date as the "From" date on the claim.

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Save time and money by going electronic!

Did you know that every paper check and/or paper remittance advice sent by National Government Services is tapping into the Medicare Trust Fund?

In order to save those funds, your company should go electronic by using Electronic Funds Transfer and Electronic Remittance Advices.

Electronic Funds Transfer:
With Electronic Funds Transfer (EFT), your payments will be automatically deposited into the bank account you designate. This completely eliminates unnecessary trips to the bank and allows you access to your money faster because there is no mail time involved. EFTs are now **mandatory** for all DME MAC suppliers. Complete the CMS-588 Form as soon as possible to avoid delays in payments.

Electronic Remittance Advice:
An Electronic Remittance Advice (ERA) will allow your company to receive notification from National Government Services up to 1 week earlier. By receiving your remittance advices earlier, you can work denials sooner, start the appeals process earlier when needed and resubmit your claims faster.

By using ERAs, your remittances can be downloaded to your computer, stored electronically and with most systems can also be posted automatically. ERAs will drastically reduce the time you currently spend posting the information manually and will help the environment by eliminating the need for paper copies and storage space.

To start the enrollment for EFTs and ERAs go to www.NGSMedicare.com, select Jurisdiction B DME MAC and click the "Think Green and Go Paperless" icon.

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Jurisdiction B Durable Medical Equipment
Medicare Administrative Contractor (DME MAC)
1st Quarter 2010 Top Claim Submission Errors

The Jurisdiction B DME MAC conducted claim analysis for the first quarter of calendar year 2010 (January – March) of issues related to claim submission errors. Below is a chart listing the top claim submission errors as well as helpful tips on how to decrease the number of errors. The overall total of denied claims for the first quarter was 732,309.

ANSI Code	Category	Denial Type	January 2010	February 2010	March 2010	1sth Quarter Total	% of Denials
CO-18	**Duplicate Claim**	**Duplicate**	**26,902**	**24,581**	**36,120**	**87,603**	**11.96%**
OA-24	**Payment for charges adjusted. Charges covered under a capitation agreement/ managed care plan.**	**Eligibility**	**12,150**	**13,691**	**14,398**	**40,239**	**5.49%**
CO-151	**Equipment is the same or similar to equipment already being used.**	**Same/Similar**	**10,002**	**9,898**	**13,366**	**33,266**	**4.54%**
OA-109	**Claim not covered by this payer/contractor. You must send**	**Jurisdiction**	**7,511**	**8,612**	**9,914**	**26,087**	**3.56**

	the claims to the correct payer/ contractor.						
CO-176	**Payment denied because the prescription is not current.**	**Return/Reject**	**6,162**	**7,329**	**11,385**	**24,876**	**3.40%**
CO-173	**Payment adjusted because this service was not prescribed by a physician.**	**Return/Reject**	**4,966**	**4,433**	**6,278**	**15,677**	**2.14%**
CO-13	**The date of death precedes the date of service.**	**Return/Reject**	**3,531**	**3,820**	**4,586**	**11,937**	**1.63%**
CO-22	**Payment adjusted because this care may be covered by another payer per coordination of benefits.**	**Eligibility**	**3,243**	**3,122**	**5,432**	**11,797**	**1.61%**
PR-31	**Claim denied as patient cannot be identified as our insured.**	**Eligibility**	**1,128**	**1,194**	**1,637**	**3,959**	**0.54%**

CO-189	**"Not otherwise classified" or "unlisted" procedure code**	**Return/Reject**	**1,228**	**1,338**	**1,336**	**3,902**	**0.53%**

1. CO-18 Duplicate claims

The Jurisdiction B DME MAC receives a large quantity of claims that result in duplicate denials. The duplicate claim submission denial is the number one claims submission error. Generally claim submission errors are services/items previously processed for the same patient, date of service and HCPCS code.

Suppliers are reminded to allow 14 days for electronically submitted claims and 29 days for hard copy claims before resubmitting a claim to the DME MAC. Suppliers should utilize the Claim Status Inquiry (CSI) or the Interactive Voice Response (IVR) unit at 1-877-299-7900 before resubmitting the claim for payment.

2 OA-24 Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan

The Jurisdiction B DME MAC records indicate that the beneficiary is enrolled in a Medicare Advantage plan, often referred to as a Health Maintenance Organization (HMO). If the beneficiary elects to receive his or her Medicare benefits through a managed care plan, the beneficiary usually is required to receive all his or her care from doctors, hospitals, and other health care providers that are part of the plan. Beneficiaries enrolled in a Medicare HMO will receive an identification card from their Medicare HMO. Beneficiaries, doctors, hospitals, or any other health care provider must contact the HMO for details pertaining to coverage requirements. The DME MACs do not process claims for Medicare HMOs. Suppliers must submit their claim to the appropriate insurance carrier for the specific HMO in which the beneficiary is enrolled. The Jurisdiction B DME MAC encourages suppliers to utilize the Customer Care Interactive Voice Response (IVR) system or Claim Status Inquiry (CSI) for assistance in determining whether the beneficiary is enrolled in a Medicare Advantage Plan/HMO.

By selecting Option 2 from the main menu of the IVR, suppliers will be able to obtain the Medicare HMO number, name, address, telephone number and effective/termination date of the plan. The IVR system is available from 7 a.m. to 6 p.m. ET, Monday through Friday, and 7 a.m. to 3 p.m. most Saturdays. Suppliers may access the IVR system by dialing 1-877-299-7900. For additional information regarding the IVR unit, suppliers should refer to the IVR guide located at www.NGSMedicare.com. Click on the Resources menu option, select Contact Us, and then select Interactive Voice Response (IVR).

Online eligibility is also available through the CSI application for all suppliers. The CSI application and manual is available on the National Government Services Web site at

www.NGSMedicare.com. Click on the Claims menu option, select Electronic Data Interchange, and then select Enrollment Information and Forms.

3 CO-151 Equipment is the same of similar to equipment already being used

Suppliers should evaluate the patient's history during the intake process to determine if the same or similar equipment was previously obtained. Suppliers may utilize Claim Status Inquiry (CSI) or the Interactive Voice Response (IVR) unit at 1-877-299-7900 to determine if the beneficiary's record indicates he/she already has the same/similar equipment. If the beneficiary wants the same/similar equipment and agrees to be financially liable, the supplier should have the beneficiary sign an Advance Beneficiary Notice of Noncoverage (ABN), and submit the claim with the GA modifier to indicate an ABN is on file. However, if a claim denies because the patient has previously received the same/similar equipment, and the supplier was unaware of the previous purchase, the supplier should refund the beneficiary (if applicable). The supplier may choose to exercise his/her right to request a redetermination. Redetermination requests should be submitted to the following address:

Redeterminations
P.O. Box 6036
Indianapolis, Indiana 46206-6036

4. OA-109 Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor

National Government Services is the Jurisdiction B DME MAC that processes DMEPOS claims for the states of Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin. DMEPOS jurisdiction is based on the beneficiaries address on file with the Social Security Administration. Suppliers should verify that the address they have on file for the beneficiary is the same address on file with Social Security Administration. This will help to ensure claims are sent to the correct DME MAC jurisdiction for processing. Claims submitted to an incorrect DME MAC jurisdiction will receive a denial indicating "Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor."

5. CO-176 Payment denied because the prescription is not current

The Jurisdiction B DME MAC encourages suppliers to review the medical policies, referred to as Local Coverage Determinations, to verify whether or not an initial, revised, or recertification Certificate of Medical Necessity (CMN) is required for a specific item. When submitting claims that require a CMN, suppliers should ensure that all sections of the CMN are completed prior to submitting the claim to the DME MAC. Suppliers should submit the CMN with the initial claim only, and wait 24-48 hours before submitting any subsequent claims. The Local Coverage

Determinations (LCDs) are located on National Government Services Web site at: www.NGSMedicare.com

However, if a claim denies because the patient has previously received same/similar equipment, and the supplier was unaware of the previous purchase, the supplier should refund the beneficiary or exercise his/her appeal rights and request a redetermination. Redetermination requests should be submitted to the following address:

Jurisdiction B DME MAC
Redeterminations
P.O. Box 6036
Indianapolis, Indiana 46206-6036

6. CO-173 Payment adjusted because this service was not prescribed by a physician

The Jurisdiction B DME MAC encourages suppliers to review medical policies to verify whether or not the items or services routinely provided to Medicare beneficiaries require an initial, revised or recertification CMN. When submitting claims that require a CMN, suppliers should ensure that all sections of the CMN are completed prior to claim submission to the DME MAC. Suppliers should submit the CMN with the initial claim only and wait 24-48 hours before submitting any subsequent claims. The medical policies are located on National Government Services Web site at: www.NGSMedicare.com under "Quick Links."

7. CO-13 The date of death precedes the date of service

Medicare Part B coverage was not valid when the patient received this item and/or service. Expenses were incurred after coverage was terminated, prior to coverage, date of death precedes the date of service or Medicare was unable to identify the patient as an insurer. Suppliers should contact the beneficiary to whom they are providing service, to determine whether the beneficiary is still using the supplier's equipment. It is also recommended that suppliers check their patients' Health Insurance Claim card and Medicare records for valid coverage dates and for correct patient information prior to claim submission.

8. CO-22 Payment adjusted because this care may be covered by another payer per coordination of benefits

The Jurisdiction B DME MAC records indicate that Medicare is the secondary payer. When Medicare is the secondary payer, suppliers must send the claim to the primary payer first and then submit the claim to Medicare with a copy of the primary payer's Explanation of Benefits (EOB) notice. When claims are submitted to Medicare as primary and another insurer is actually the primary payer, claims will be denied with the following explanation: "Our records show that

Medicare is your secondary payer. This claim must be sent to your primary insurer first. Resubmit this claim with a copy of the primary payment notice". Suppliers must send these claims to the correct payer/contractor and then resubmit the claim to Medicare with a copy of the primary payment notice or the Explanation of Benefits. If the beneficiary's Medicare Secondary Payer (MSP) records are outdated, suppliers should advise the beneficiary to contact the Coordination of Benefits Contractor at 1-800-999-1118 to have his/her MSP control file updated.

9. PR-31 Claim denied as patient cannot be identified as our insured.

Medicare Part B coverage was not valid when the patient received this item and/or service. Expenses were incurred after coverage was terminated, prior to coverage, the date of death precedes the date of service or Medicare was unable to identify the patient as an insurer. Suppliers are encouraged to utilize the Interactive Voice Response (IVR) system and/or Claim Status Inquiry (CSI) to validate coverage dates prior to claim submission. Additionally, suppliers should check the patient's Medicare card for valid coverage dates and for correct patient information prior to claim submission.

10. CO-189 Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.

When billing Medicare for a Medicare covered item for which a HCPCS code has not yet been established, suppliers are instructed to use a "Not Otherwise Classified" (NOC) code. When submitting a claim using a NOC code, suppliers must indicate in Item 19 of the CMS 1500 claim or the corresponding Note Segment (NTE) field of the electronic claim format, a detailed description of the item being billed as well as any useful information to help correctly adjudicate the claim. If additional information is needed for processing, the supplier will receive an Additional Documentation Request from the contractor.

However, if a specific HCPCS code has been established for the item, suppliers should no longer use the NOC code; suppliers must submit their claims with the specific HCPCS code assigned to the item. Failure to do so will result in a CO-189 denial. When a CO-189 error is received, the supplier must resubmit the corrected claim for processing.

To determine if an item has been assigned a specific HCPCS code, suppliers are encouraged to utilize the Medicare Pricing, Data Analysis, and Coding System (DMECS) available at www.dmepdac.com. To look up an item, click on the link titled "DMECS Coding." In the section titled, "Search by HCPCS Information," type a key word that describes the item in the "KEYWORD" box, then click the "GO" button to the right of that section. A list of items

containing the key word along with a list of HCPCS will appear. To view more detail about the item/HCPCS code, click on the HCPCS code.

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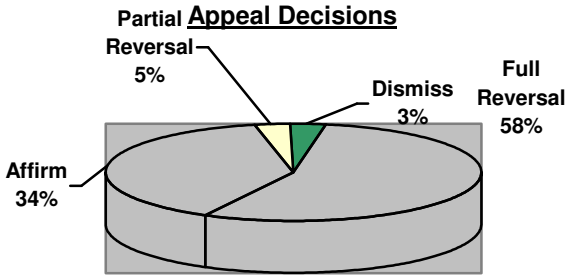
Jurisdiction B
DME MAC Appeals Update

December 31, 2009

Redeterminations Timeliness

- Processed timeliness: 100%
- Average days processed: 29



- 0 cases pending over 60 days
- Inventory pending: 8,555 (average adjustments to pending = -5,715)

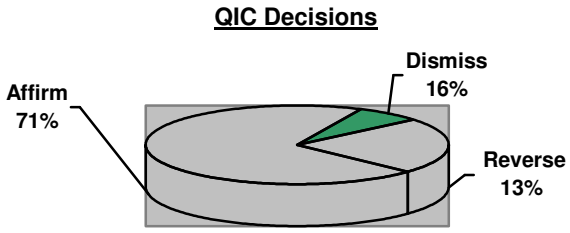
Top Issues for Received Redeterminations

- Oxygen denials no recertification – 8%
- PAP for medical necessity – 6%
- Wheelchair options for same/similar – 3%

QIC Timeliness

- Effectuated timeliness: 100%
- Average # of days to forwarded file requests: 3

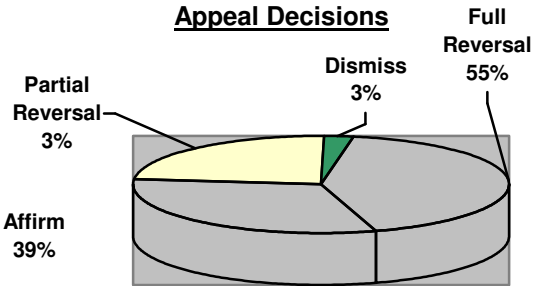
(CMS standard 5 days, internal standard 4 days)



March 31, 2010

Redeterminations Timeliness

- Processed timeliness: 100%
- Average days processed: 29



- 0 cases pending over 60 days
- Inventory pending: 9,491 (average adjustments to pending = -4,692)

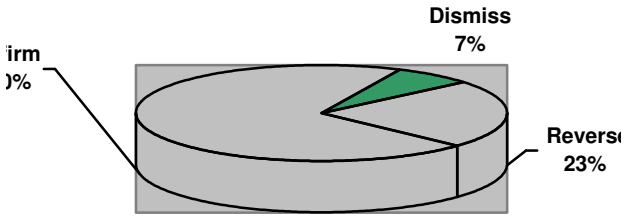
Top Issues for Received Redeterminations

- Oxygen denials no recertification – 7%
- Nebulizer for medical necessity– 4%
- Wheelchair options for medical necessity – 2%

QIC Timeliness

- Effectuated timeliness: 100%
- Average # of days to forwarded file requests: 3

(CMS standard 5 days, internal standard 4 days)



CMS CENTERS for MEDICARE & MEDICAID SERVICES

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Jurisdiction B DME MAC Provider Contact Center Statistics

4th Quarter Timeliness – Oct – Dec, 2009

ASA - :51 seconds
(Average Speed of Answer)

4th Quarter Quality Scores

Customer Skills - 99%
Knowledge Skills - 94%
Privacy – 98%

1st Quarter Timeliness – Jan – Mar, 2010

ASA - :53 seconds
(Average Speed of Answer)

1st Quarter Quality Scores

Customer Skills - 100%
Knowledge Skills - 95%
Privacy – 98%

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Jurisdiction B Durable Medical Equipment
Medicare Administrative Contractor (DME MAC)
First Quarter 2010
Supplier Telephone Inquiries

National Government Services has included a review of the top telephone inquiries for Durable Medical Equipment Prosthetic Orthotics and Supplies (DMEPOS) for the first quarter of calendar year 2010 (January – March). The Provider Outreach and Education team works closely with the Provider Contact Center (PCC) to develop educational materials to ensure the supplier community is knowledgeable on the top telephone inquiries. The National Government Services Provider Contact Center received a total of 63,045 telephone inquiries for the first quarter of 2010. The following provides a listing of the top ten Jurisdiction B DME MAC supplier telephone inquiries for the first quarter:

1. Claim Denials – Frequency Limitation (5,461)

Suppliers should refer to each individual medical policy to verify coverage criteria for an item and/or service. When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, the supplier must obtain information supporting the medical necessity for the higher utilization. This information must be retained in the supplier's file and be available to the Jurisdiction B DME MAC upon request. Medical policies are located on the National Government Services Web site at: www.NGSMedicare.com under the Coverage menu.

For medical necessity denials, suppliers are given the option to request a redetermination by submitting supporting documentation along with the request.

Please submit redetermination requests to the following address:

Redeterminations
P.O. Box 6036
Indianapolis, Indiana 46206-6036

2. Claim Status – Payment/Explanation/Calculation (4,198)

DMEPOS items and/or services are paid based on three payment methodologies: (1) fee schedules, (2) reasonable charge and (3) drugs and biologicals. Most DME payments are based on a fee schedule. A standard fee is established for each DMEPOS item by state.

The Medicare Pricing, Data Analysis, and Coding Contractor (PDAC) can assist DMEPOS suppliers with locating fee schedule allowables for a particular product by state. In addition, the PDAC is responsible for determining the appropriate HCPCS code to use when submitting

DMEPOS claims to Medicare, processing coding verification applications, assigning existing HCPCS codes to products and maintaining a NDC/HCPCS code crosswalk applicable to DME billing. For additional information regarding pricing, please visit the Pricing, Data Analysis, and Coding Contractor's Web site at: https://www.dmepdac.com/.

3. Unprocessable - Submitted to Incorrect Program (4,173)

The traditional fee-for-service Medicare program consists of two parts; Part A, Hospital Insurance and Part B, Medical Insurance. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Part B covers doctors' services, outpatient care, some of the services of physical and occupational therapists, some home health care and medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). Suppliers should refer to the CMS Internet-Only Manual (IOM) for the Medicare coverage criteria requirements of items and services specifically for each Medicare program. The CMS IOM can be located by copying the following web address into an internet browser: http://www.cms.hhs.gov/Manuals/IOM/list.asp

4. Coding – Modifiers (4,156)

Claims submitted to the Medicare program with invalid or incorrect HCPCS and modifier combinations will result in a denial due to the claim lacking the information which is needed for complete adjudication with ANSI code CO-16. Claims denied CO-16 are not eligible for a redetermination or reopening request. This is because an initial claim determination could not be made with the coding information submitted. All CO-16 denials must be resubmitted with the complete and correct coding.

For a complete listing of the HCPCS Modifiers, please consult the Jurisdiction B DME MAC Supplier Manual, Chapter 14 Level II HCPCS Codes and HCPCS Modifiers. Special coverage guidelines are published in each individual medical policy. The local coverage determinations and policy articles provide specific instructions for using the informational modifiers listed within the medical policy. The LCDs and policy articles may be accessed through the National Government Services Web site at http://www.NGSMedicare.com, click on the Coverage menu option and select Local Medical Policy or click on the Local Medical Policy link under "Quick Links."

Suppliers may also utilize the DME Coding System (DMECS), to verify if the HCPCS code requires a primary pricing modifier. DMECS provides HCPCS coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, DMEPOS items and CMS national fee schedules. To search for HCPCS and modifier coding or to find out more about

the DME Coding System, please visit the Pricing, Data Analysis and Coding Contractor's Web site at https://www.dmepdac.com/dmecs/index.html

5. Claim Denials – Medical Necessity (3,245)

Suppliers are encouraged to consult the Local Coverage Determinations (LCD) and Policy Articles for individual medical policy coverage criteria, which are located on the National Government Services Web site (www.NGSMedicare.com). For medical necessity denials, suppliers are given the option to submit the claim along with supporting documentation as an appeal request. Suppliers should submit redetermination requests to the following address:

Redeterminations
P.O. Box 6036
Indianapolis, IN 46206-6036

6. Claim Denial – DME POS Issues (3,002)

Maintenance and Servicing

Medicare covers maintenance and servicing of some DME items depending upon the situation and the benefit category into which the item falls. For detailed information on the coverage and billing of maintenance and servicing, refer to the Jurisdiction B Supplier Manual, chapter 15 located on the www.NGSMedicare.com Web site.

Break in Need/Break in Service

Under the Medicare Part B program, monthly rental payments may be made for certain DME that is provided to a beneficiary for a period of continuous use. If there is an interruption in the use/medical need for capped rental equipment, a PEN pump, or oxygen equipment that is greater than 60 days plus the days remaining in the month the use ceases, the period of continuous use leading up to the break ends and a new period of continuous use begins when the beneficiary again has a medical need for the equipment. (For oxygen equipment, a new period of continuous use may begin following a break in need that is greater than 60 days plus the days remaining in the last paid rental month, only when that break in need occurs during the 36-month payment period.) Suppliers must provide break in need/break in service (BIS) information on claims following a break in need to identify that a new capped rental period is beginning. A physician's order, new initial Certificate of Medical Necessity (CMN), if applicable, new testing, if applicable, and all medical necessity criteria must be met as outlined in the LCD.

Suppliers who have an Administrative Simplification Compliance Act (ASCA) waiver on file should utilize the Jurisdiction B DME MAC Break in Service Form and submit it with their CMS-1500 claim form. The break in service/break-in-need form is located at the end of this chapter and

is also available on the National Government Services Web site at www.ngsmedicare.com/ngsmedicare/DMEMAC/Resources/Forms/IndexFormsDMEMAC.aspx.

For suppliers submitting claims electronically, the break-in-need (BIS) information is reported in the Note (NTE) segment in the order and format as follows.

Order:

1. The abbreviation "BIS" for break in service/break in need
2. The "pick up" date and the "delivery" date
3. The beneficiary's previous ICD-9-CM diagnosis code and the new ICD-9-CM diagnosis code

The "pick up" date refers to the date the new and/or previous supplier removes the piece of equipment from the patient's home. The "delivery" date will be the most recent date the new item was delivered.

Format: BIS MMDDYY MMDDYY ICD-9 ICD-9

For detailed information pertaining to Interruptions in a Period of Continuous Use (break in need/break in service), refer to the Jurisdiction B Supplier manual located on the www.NGSMedicare.com Web site.

7. Claim Denials – Duplicate (2,309)

The Jurisdiction B DME MAC receives a large quantity of claims that result in duplicate denials. The duplicate claim submission error is often the number one claim submission error. Generally, claim submission errors are services/items previously processed for the same patient, date of service and HCPCS code.

Suppliers are reminded to allow 14 days for electronically submitted claims and 29 days for hard copy claims before resubmitting a claim to the DME MAC. Suppliers should utilize the Claim Status Inquiry (CSI) or the Interactive Voice Response (IVR) unit at 1-877-299-7900 before resubmitting the claim for payment.

For additional information regarding steps to take to avoid duplicate denials, please review the article titled "*How to Prevent Duplicate Denials" on* the National Government Services Web site at: www.NGSMedicare.com. Once you are in the DME portal pages select *Claims* from the menu option and then click on *Tool Kits.*

8. Entitlement – Same/Similar (1,976)

Claims submitted for items that are the same or similar to equipment already being used by the beneficiary will deny with ANSI code CO-151 (Equipment is the same or similar to equipment already being used). To avoid this denial, suppliers should evaluate the patient's history during the intake process to determine if the same, or similar equipment, was previously obtained by the patient. Suppliers may utilize Claim Status Inquiry (CSI) or the Interactive Voice Response (IVR) unit at 1-877-299-7900 to determine if the beneficiary's record indicates he or she already has the same or similar equipment. If the beneficiary wants the equipment even though they already own or rent the same or similar equipment, and he or she agrees to be financially liable, the supplier should have the beneficiary sign an Advance Beneficiary Notice of Noncoverage (ABN) accepting financial responsibility for the item since it will not be covered by Medicare. The supplier would then submit the claim with the GA modifier to indicate an ABN is on file. However, if a claim denies because the patient has previously received the same/similar equipment, and the supplier was unaware of the previous purchase, the supplier should refund the beneficiary (if applicable). The supplier may choose to exercise his/her right to request a redetermination. Redetermination requests should be submitted to the following address:

Redeterminations
P.O. Box 6036
Indianapolis, Indiana 46206-6036

9. General Information – Other Issues (1,851)

Suppliers are encouraged to visit the National Government Services Web site (www.NGSMedicare.com) frequently to stay abreast of Medicare changes. For the latest Medicare news, policy changes, claim filing issues and other important information visit the Jurisdiction B DME MAC "What's New" section of the National Government Services Web site.

10. Claim Denials – Statutory Exclusion (1,810)

Section 1861(s) of the Social Security Act defines medical services that are covered by Medicare, which in turn are implemented through federal regulations, Medicare manuals, instructions from the Centers for Medicare & Medicaid Services (CMS) and decisions by the individual durable medical equipment Medicare administrative contractors (DME MACs) that administer the Medicare program in each jurisdiction. Services that are not included in those definitions or instructions are not covered by Medicare. CMS has provided instructions regarding the general exclusions from Medicare coverage in the CMS, IOM Publication 100-02 Medicare Benefit Policy Manual, Chapter 16 *General Exclusions from Coverage.* To access this manual go to the CMS Web site at www.cms.hhs.gov, select *Manual* from the top 10 links and the select Internet-Only Manual (IOM).

Suppliers are encouraged to review the Jurisdiction B DME MAC Supplier Manual, chapter 17 *Medicare Benefit and Denial Categories* for an overview of denial categories billed to Medicare. Special coverage guidelines are published in individual medical policy, which can be found on the National Government Services Web site at www.NGSMedicare.com. In addition, the Local Coverage Determination and Policy Articles both provide specific instructions when an item or service indicated in the LCD and policy article are deemed to be excluded from coverage. The LCDs and policy Articles may be accessed through the National Government Services Web site at www.NGSMedicare.com, click on the Coverage menu option and select Local Coverage Determination.

The Top Jurisdiction B Durable Medical Equipment
Medicare Administrative Contractor (DME MAC)
First Quarter 2010
Supplier Written Inquiries

National Government Services has included a review of the top supplier written inquiries for Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) for the first quarter of calendar year 2010 (January – March). The National Government Services Written Correspondence Unit received a total of 4,046 written inquires for the first quarter. The following provides a listing of the top ten Jurisdiction B DME MAC Supplier Written Inquiries for the first quarter.

1. Claim Status – Claim Status (567)

The Jurisdiction B DME MAC telecommunications system is equipped with an Interactive Voice Response (IVR) Unit. Suppliers can obtain claim status information from the IVR from 6:00 a.m. to 7:00 p.m. Eastern Time (ET), Monday through Friday, and 7:00 a.m. to 3:00 p.m. ET most Saturdays by calling 1-877-299-7900. For additional information regarding the IVR unit suppliers should refer to the IVR guide located at www.NGSMedicare.com, click on the Resource menu option, select Contact Information and then select Interactive Voice Response (IVR).

All suppliers submitting claims electronically or on paper are eligible for Claim Status Inquiry (CSI). This applies to participating and nonparticipating suppliers. With access to CSI, submitters can view the status of all claims as they appear in the DME MAC claims processing system. This includes paid, denied and pending claims.

The CSI application and manual is available on the National Government Services Web site at www.NGSMedicare.com, click on the Claims menu option, select Electronic Data Interchange and then select Enrollment Information and Forms.

2. Claim Denials – DMEPOS Issues (515)

Maintenance and Servicing

Medicare covers maintenance and servicing of some DME items depending upon the situation and the benefit category into which the item falls. For detailed information on the coverage and billing of maintenance and servicing, refer to the Jurisdiction B Supplier Manual, chapter 15 located on the National Government Services Web site at: http://www.ngsmedicare.com/content.aspx?CatID=3&DOCID=240.

Break in Need/Break in Service

Under the Medicare Part B program, monthly rental payments may be made for certain DME that is provided to a beneficiary for a period of continuous use. If there is an interruption in the use/medical need for capped rental equipment, a PEN pump, or oxygen equipment that is greater than 60 days plus the days remaining in the month the use ceases, the period of continuous use leading up to the break ends and a new period of continuous use begins when the beneficiary again has a medical need for the equipment. (For oxygen equipment, a new period of continuous use may begin following a break in need that is greater than 60 days plus the days remaining in the last paid rental month, only when that break in need occurs during the 36-month payment period.**)** Suppliers must provide break in need/break in service (BIS) information on claims following a break in need to identify that a new capped rental period is beginning. A physician's order, new initial Certificate of Medical Necessity (CMN), if applicable, new testing, if applicable, and all medical necessity criteria must be met as outlined in the LCD.

Suppliers who have an Administrative Simplification Compliance Act (ASCA) waiver on file should utilize the Jurisdiction B DME MAC Break in Service Form and submit it with their CMS-1500 claim form. The break in service/break-in-need form is located at the end of this chapter and is also available on the National Government Services Web site at.
http://www.ngsmedicare.com/content.aspx?CatID=3&DOCID=723

For suppliers submitting claims electronically, the break-in-need (BIS) information is reported in the Note (NTE) segment in the order and format as follows.

Order:

1. The abbreviation "BIS" for break in service/break in need
2. The "pick up" date and the "delivery" date
3. The beneficiary's previous ICD-9-CM diagnosis code and the new ICD-9-CM diagnosis code

The "pick up" date refers to the date the new and/or previous supplier removes the piece of equipment from the patient's home. The "delivery" date will be the most recent date the new item was delivered.

Format: BIS MMDDYY MMDDYY ICD-9 ICD-9

For detailed information pertaining to Interruptions in a Period of Continuous Use (break in need/break in service), refer to the Jurisdiction B Supplier manual located on the www.NGSMedicare.com Web site.

3. Claim Denials – Coding Errors including Modifiers (322)

Claims submitted to the Medicare program with invalid or incorrect HCPCS and modifier combinations will result in a denial due to the claim lacking the information which is needed for complete adjudication with ANSI code CO-16. Claims denied CO-16 are not eligible for a redetermination or reopening request. This is because an initial claim determination could not be made with the coding information submitted. All CO-16 denials must be resubmitted with the complete and correct coding.

For a complete listing of the HCPCS Modifiers, please consult the Jurisdiction B DME MAC Supplier Manual, Chapter 14 Level II HCPCS Codes and HCPCS Modifiers. Additionally, specific instructions regarding modifier usage is located in the Jurisdiction B Supplier Manual, Chapter 15, DMEPOS Payment Categories. The local coverage determinations and policy articles provide specific instructions for using the informational modifiers listed within the medical policy. The LCDs and policy articles may be accessed through the National Government Services Web site at www.NGSMedicare.com, click on the Coverage menu option and select Local Medical Policy, or click on Local Medical Policy under "Quick Links."

Suppliers may also utilize the DME Coding System (DMECS), to verify if the HCPCS code requires a primary pricing modifier. DMECS provides HCPCS coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, DMEPOS items and CMS national fee schedules. To search for HCPCS and modifier coding or to find out more about the DME Coding System, please visit the Pricing, Data Analysis and Coding Contractor's Web site at https://www.dmepdac.com/dmecs/index.html

4. Financial Information – Overpayments (289)

Suppliers should send refund requests to the National Government Services ORU with a copy of the original refund request letter received from ORU. Also, be sure to reference the DCN in any communication with the DME MAC. This DCN is used to track the refund. This letter is the only notification from the DME MAC prior to an offset occurring. Suppliers are encouraged to respond to all refund request letters received from the DME MAC to avoid an offset.

Please send all overpayment requests to the following address:

Overpayment Recovery Unit
ORU—DME MAC—Indiana
Lockbox # 660078
Indianapolis, Indiana 46266-0078

The IVR unit will allow suppliers to research offset information and voluntary refunds. Suppliers should utilize the IVR unit at 877-299-7900 for both offset and voluntary refund information.

5. RTP/Unprocessable – Missing/Invalid Diagnosis (284)

The diagnosis code is required when submitting a claim to Medicare and is reported on the Medicare 1500 paper claim in Item 21 or the corresponding segment of the electronic claim format. It is the supplier's responsibility to code the diagnosis to the highest specified International Classification of Diseases, Clinical Modification, 9th Revision (ICD-9-CM) code. If suppliers are unable to determine the highest level of specificity, the supplier is encouraged to contact the ordering physician. If claims received are not coded to the highest level of specificity, the claim will be returned to the supplier as unprocessable. The supplier must correct the diagnosis code and resubmit the claim.

The diagnosis pointer is also required and must be reported in Item 24e of the 1500 paper claim form or the corresponding segment of the electronic claim format. In Item 24e (or the corresponding segment of the electronic format), the supplier must indicate the number that corresponds to the diagnosis code reported in Item 21 that supports the need for the item being billed on that line. The supplier must enter only one number 1, 2, 3, or 4 in item 24e.

6. Return to Provider Unprocessable – Submitted to Incorrect Program (277)

The traditional fee-for-service Medicare program consists of two parts: Part A, Hospital Insurance and Part B, Medical Insurance. Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Part B covers doctors' services, outpatient care, some of the services of physical and occupational therapists, some home health care and medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). Suppliers should refer to the CMS IOM Publications for Medicare coverage criteria requirements of items and services specific for each Medicare program. The CMS IOM Publications can be located by copying the following web address into an internet browser: www.cms.hhs.gov/Manuals/IOM/list.asp

7. RTP/Unprocessable—RTP/Unprocessable (230)

Claims that have been return/rejected to the provider as unprocessable, must be corrected by the supplier and resubmitted. The reopening department is not able to correct return/rejected claims via the reopening process. Suppliers may submit faxed reopening requests to resolve minor errors or omissions to National Government. If a supplier faxes a request to Reopenings, and that request was a return/reject which should have been corrected by the supplier and resubmitted, the Reopenings staff will treat the request as if it were written correspondence and the supplier

will receive a written response from the written correspondence unit instructing them to correct and resubmit their claim.

8. Claim Denials – Medicare Secondary Payer (201)

Suppliers should utilize the Medicare Secondary Payer Questionnaire (MSPQ) when services are provided to a Medicare beneficiary. When correctly completed, the MSPQ will assist suppliers in determining the correct primary payer. The supplier must always determine if the nature of the services are accident-related. If so, the supplier must then determine if no-fault or liability insurance is available. If either insurance is available, the supplier must bill the insurer for 120 days or until a denial is received before billing Medicare. For more information on MSP, visit the National Government Services Web site at: http://www.ngsmedicare.com/ngsmedicare/DMEMAC/Coverage/MedicareSecondaryPayer/IndexMe diSecPayerDMEMAC.aspx, or visit the CMS IOM Publication 100-05, *Medicare Secondary Payer Manual* at www.cms.hhs.gov/Manuals/IOM/list.asp

9. Claim Denials – Duplicates (171)

The Jurisdiction B DME MAC receives a large quantity of claims that result in duplicate denials. The duplicate claim submission is often the number one claims submission error. Generally claim submission errors are services/items previously processed for the same patient, date of service, and HCPCS code.

Suppliers are reminded to allow 14 days for electronically submitted claims and 29 days for hard copy claims before resubmitting a claim to the DME MAC. Suppliers should utilize Claim Status Inquiry (CSI) or the Interactive Voice Response (IVR) unit at 1-877-299-7900 before resubmitting the claim for payment.

If you received a duplicate claim denial for an item that is not an actual duplicate item, you may request an appeal. Submit supporting documentation along with your appeal request, within 120 days from the date of the initial determination, to the following address:

Redeterminations
P.O. Box 6036
Indianapolis, IN 46206-6036

For additional information regarding steps to take to avoid duplicate denials, please review the article titled "*Duplicate Denials" on* the National Government Services Web site at: www.NGSMedicare.com. Once you are in the DME portal pages select *Claims* from the menu option and then click on *Tool Kit.*

10. Claim Denials – Medical Necessity (170)

Suppliers should refer to each individual medical policy to verify coverage criteria for an item and/or service. The medical policies can be found on the National Government Services Web site at www.NGSMedicare.com. For medical necessity denials, suppliers are given the option to submit the claim along with supporting documentation as an appeal request. Suppliers should submit redetermination requests to the following address:

DME MAC Redeterminations
P.O. Box 6036
Indianapolis, Indiana 46206-6036

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Jurisdiction B Durable Medical Equipment
Medicare Administrative Contractor
Overpayment Recovery Unit Update

	3rd Qtr 2009 (July-Sept)	4th Qtr 2009 (Oct-Dec)	1st Qtr 2010 (Jan-March)
Overpayments Closed: *(Includes Voluntary Refunds)*	12,288	4,306	8,377

	3rd Qtr 2009 Timeliness 09/30/2009	4th Qtr 2009 Timeliness 12/31/2009	1st Qtr 2010 Timeliness 03/30/2009
Overpayments: (45 days)	99.90%	100%	100%
Voluntary Refunds: (60 days)	100%	100%	100%

****

Communication Topics:

- If sending in a request for a Supplier identified overpayment, do not also send a voluntary refund.
- Do not send a refund based on information seen on a remittance advice. Claims adjusted that have a lower payment amount will cause a demand letter to be generated.
- Please be sure to send the correct form.
- Please be sure to use the correct fax number for ***non-MSP*** overpayments.
- Reminder offsets are not stopped on all claims that are appealed. Regulations only require that claims related to medical necessity denials will have the offset stopped.

Key information when corresponding with ORU (Overpayment Recovery Unit):

Offset By Fax Number:
317-913-6164

Send Correspondence To:
National Government Services
P O Box 7027
Indianapolis, In 46207-7027

Send Non-MSP Checks To:
National Government Services
PO Box 660078
Indianapolis, In 46266-0078

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

2010 Second Quarter Jurisdiction B Provider Outreach & Education Opportunities

- **Association of Indiana Home Medical Equipment Services (AIHMES) 2010 Spring Conference**
  Date: May 4-5, 2010
  Location: Indianapolis, IN
  Time: 8:30-9:30
  Topic: Medicare Updates

- **2010 Spring Medtrade**
  Date: May 11-13, 2010
  Location: Las Vegas, NV
  Time: 2:45-3:45
  Topic: Cert Updates and Medicare Updates

- **Michigan Home Health Association Annual Conference**
  Date: May 12, 2010
  Location: Mount Pleasant, MI
  Time: 2:45-4:30
  Topic: Medicare Updates

- **Ask-the-Contractor Teleconference Call**
  Date: May 2010
  Time: TBD
  Topic: TBD

- **Indiana Rural Health Association**
  Date: June 15-16, 2010

- **Positive Airway Pressure Devices Lunch & Learn Webinar**
  Date: April 27, 2010 and May 10, 2010

- **Mobility Assistive Equipment Lunch & Learn Webinar**
  Date: May 26, 2010

- **Glucose Monitors Lunch & Learn Webinar**
  Date: May 2010

- **Negative Pressure Wound Therapy Computer Based Training (CBT)**
  Date: Due to be posted in June 2010

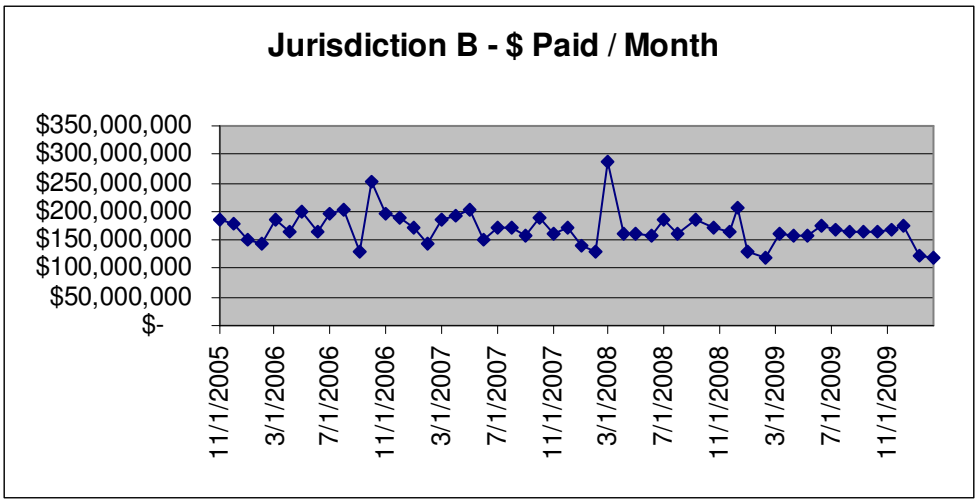
- **Pneumatic Compression Devices Lunch & Learn Webinar**
  Date: June 2010

- **Medicare 101 Billing and Intake Webinars**
  Date: June 2010

Note: POE and POCE recently attended the Vision Expo in New York, NY and the National Home Infusion Association Conference in Dallas, TX. POE recently concluded the DMEPOS Billing Workshops “filling in the blanks”. The turn out was great and the sessions went well. To those of you who were able to attend we thank you for your participation and support.

Jurisdiction B DME MAC Claims Update

Jurisdiction B - Claims Data					
Month	**Payments**	**Claims Processed**	**$ / Claim Processed**	**EMC Rate**	**Denial %**
March-08	$ 287,313,945	1,246,551	$ 230.49	98.84%	13.20%
April-08	$ 162,184,980	1,331,529	$ 121.80	98.56%	14.44%
May-08	$ 161,258,359	1,254,431	$ 128.55	98.77%	14.93%
June-08	$ 158,685,178	1,355,277	$ 117.09	98.73%	18.95%
July-08	$ 184,770,643	1,420,747	$ 130.05	98.95%	14.85%
August-08	$ 159,954,191	1,281,934	$ 124.78	98.38%	14.70%
September-08	$ 184,769,077	1,348,509	$ 137.02	98.83%	15.30%
October-08	$ 172,806,204	1,357,509	$ 127.30	98.48%	14.51%
November-08	$ 163,848,161	1,170,504	$ 139.98	99.29%	13.35%
December-08	$ 205,024,467	1,519,961	$ 134.89	98.29%	12.10%
January-09	$ 129,920,122	1,169,611	$ 111.08	98.38%	16.31%
February-09	$ 120,290,747	1,181,623	$ 101.80	98.64%	15.02%
March-09	$ 159,880,475	1,326,670	$ 120.51	98.77%	15.21%
April-09	$ 157,758,593	1,334,967	$ 118.17	98.79%	15.18%
May-09	$ 156,913,637	1,247,093	$ 125.82	98.81%	14.70%
June-09	$ 174,020,265	1,346,430	$ 129.25	98.92%	14.87%
July-09	$ 169,068,152	1,352,309	$ 125.02	98.87%	13.10%
August-09	$ 165,295,540	1,279,633	$ 129.17	98.93%	13.58%
September-09	$ 166,102,450	1,320,661	$ 125.77	99.04%	13.31%
October-09	$ 164,649,884	1,337,517	$ 123.10	98.90%	13.96%
November-09	$ 168,772,688	1,165,541	$ 144.80	99.03%	13.14%
December-09	$ 175,068,057	1,443,792	$ 121.26	99.23%	13.53%
January-10	$ 122,691,143	1,114,203	$ 110.12	98.99%	15.88%
February-10	$ 119,571,409	1,208,620	$ 98.93	99.17%	14.92%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$50,000,000
$-
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3/1/2006
7/1/2006
11/1/2006
3/1/2007
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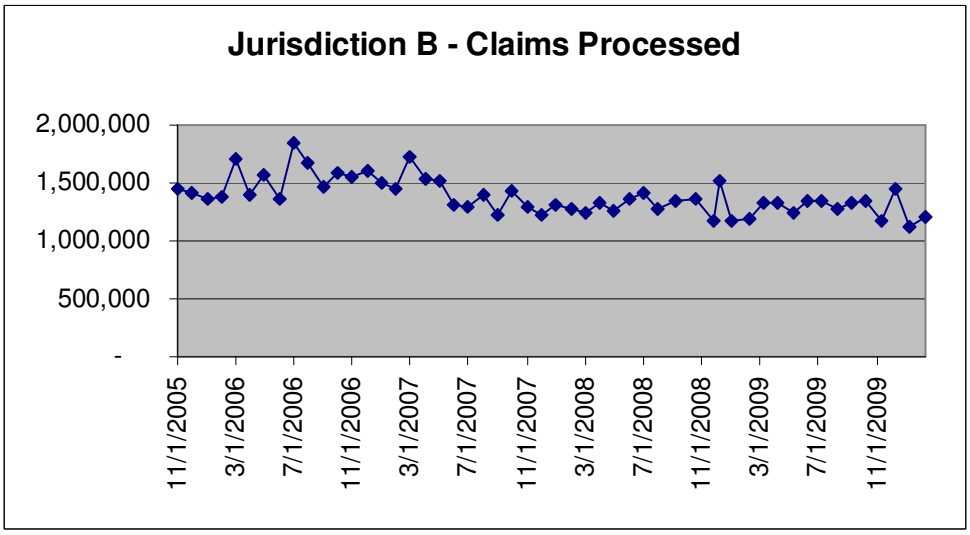
11/1/2008
3/1/2009
7/1/2009
11/1/2009


Jurisdiction B - Claims Processed
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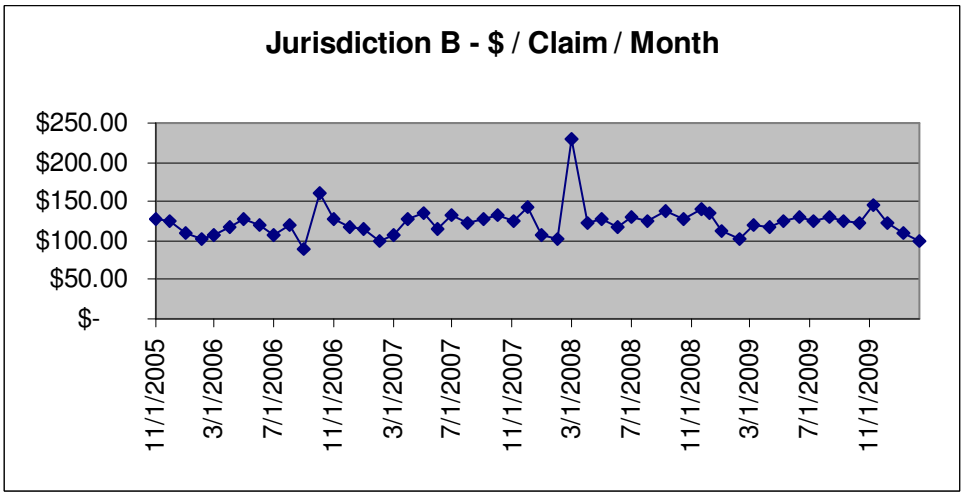
11/1/2009


Jurisdiction B - $ / Claim / Month
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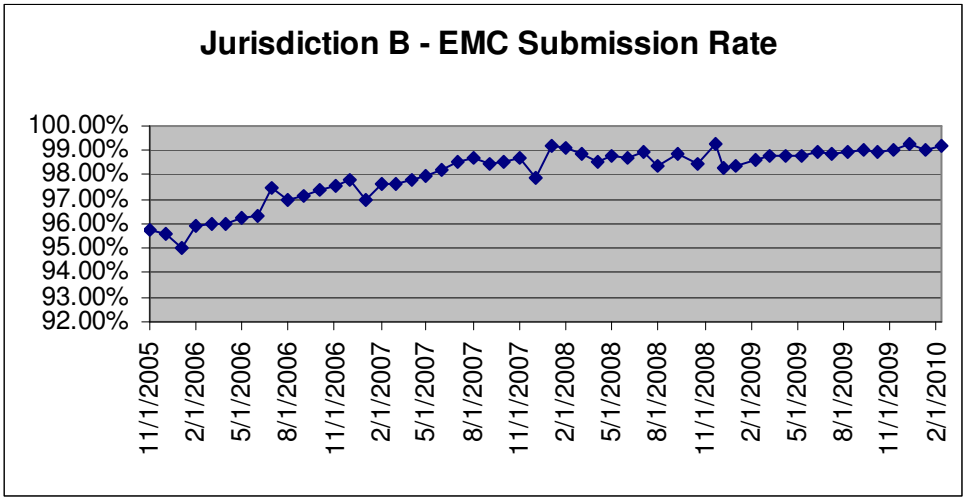
Jurisdiction B - EMC Submission Rate
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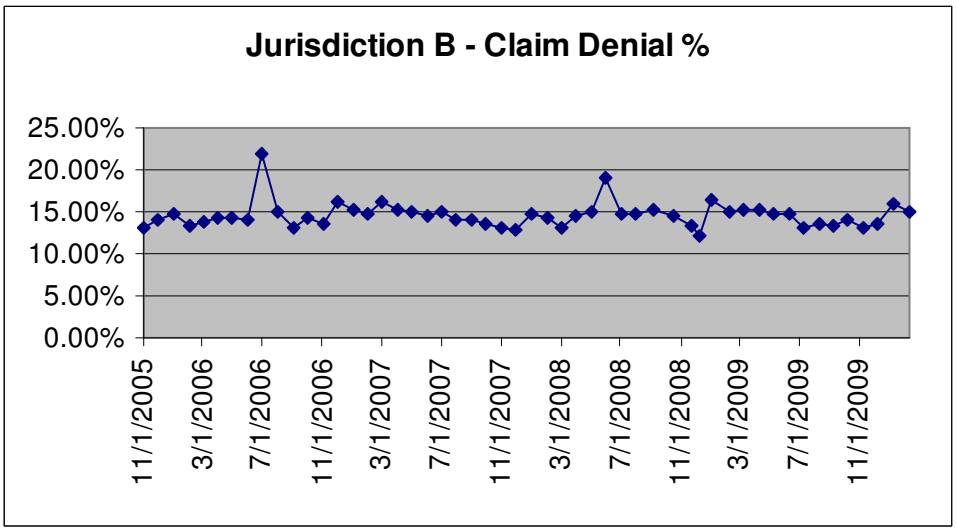
2/1/2010


Jurisdiction B - Claim Denial %
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11/1/2009