

Part 3

Submitting Medicare Claims

After a provider has made the decision to participate in the Medicare Program and has completed the enrollment process, the next decisions involve determining how to submit claims for payment. This chapter introduces billers to the general rules for providers regarding the claims submission process. There are several decisions providers must make depending upon the type of setting of the service, the size of the provider office, and individual business decisions. These decisions include issues such as whether to submit electronically or on paper, what claim forms and additional documentation to submit, and whether to accept assignment. In addition, consideration must be made regarding whether Medicare should be billed as the primary or as a secondary insurer, as well as what documentation is necessary to address discontinuation of care.

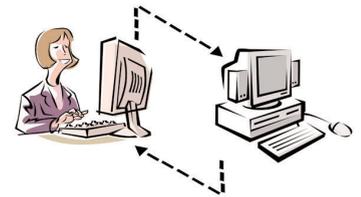
HOW DOES A PROVIDER SUBMIT A PART B CLAIM?

Submission of a claim, whether submitted electronically or on paper, is the only way a provider or beneficiary can receive reimbursement from Medicare. If there are discrepancies in a claim form, then the beneficiary may not receive full benefits.

Medicare Part B provider claims are submitted by providers to the carrier or the Durable Medical Equipment Regional Carrier (DMERC) using Form CMS-1500 (see Reference B for a copy of the Form CMS-1500 template and instructions for completion).

Claims can be submitted in one of two ways:

- ❖ Using Electronic Media Claims (EMCs) submitted from the provider's office or from a billing service contracting with the provider;
- ❖ Via a paper claim.



After October 16, 2003, providers who are not a small provider (institutional organizations with 25 or fewer full-time employees or physicians with 10 or fewer full-time employees) must submit all claims via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act (HIPAA) format.

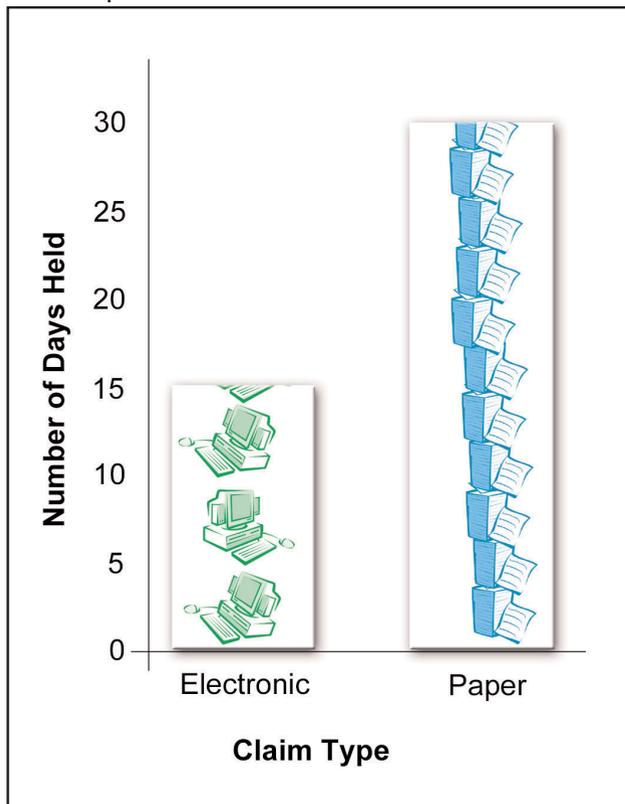
SUBMITTING CLAIMS ELECTRONICALLY

Medicare issues a sender number to a provider who intends to electronically submit Medicare claims. These EMCs are transmitted from the Part B provider's computer to the carrier or DMERC in accordance with HIPAA's American National Standards Institute (ANSI) or National Council for Prescription Drug Programs (NCPDP) electronic filing standards.

For additional information regarding HIPAA transaction standards, refer to Part 6, Introduction to HIPAA.

The EMC submission process eliminates the need for mailroom processing, thereby improving timeliness of claims. The system also releases claims payments when the Centers for Medicare & Medicaid Services (CMS) timeframe requirements are satisfied, resulting in a faster cash flow turnaround for providers. Generally, correctly filed electronic claims can be paid 14 days after the payment contractor receives the transmission, as opposed to paper claims that process in about four weeks. Payment for paper claims must be held for 28 days (see Figure 3-1).

Figure 3-1. Payment Schedule for Electronic and Paper Claims.



When a provider submits electronically, he or she will receive immediate notification that the payment contractor has received the Medicare claim. Payment contractors usually have systems that provide notification of critical claim filing errors, allowing providers to correct a claim before it enters the Medicare processing system.

This process eliminates having to wait for a denial if the claim was submitted incorrectly. Providers are then able to correct rejected claims immediately and retransmit them without waiting a day.

HOW EMC SUBMISSION WORKS

The claim is electronically transmitted via modem from the Part B provider's computer to the payment contractor's computer using the Internet. The carrier's or DMERC's modem converts the claims data to the correct format and transmits it to another system, where it is electronically checked ("edited") for required information. Claims that pass these initial edits, commonly known as *front-end edits* or *pre-edits*, are then processed according to Medicare policy and guidelines. Claims with inadequate or incorrect information do **not** pass the initial edits. Instead, they are rejected and **are not paid** because they lack sufficient information to make a payment decision. Refer to Part 5, Troubleshooting Denials and Claim Rejections, for information that will help troubleshoot an unsuccessful transmission.



Additional Claims Information

Occasionally, claims require additional information before they can be completed. A

development letter requesting the missing information is sent to the provider and/or beneficiary. When the information is received, the claim is processed for payment consideration. Failure to respond to a request for additional development may result in denial of a provider's claim.

After a successful transmission, a confirmation report or acknowledgement report is generated and is either transmitted back to the provider or placed in an electronic mailbox for the provider to download. The provider should immediately review this report carefully. The report indicates the numbers of claims accepted and the total dollar amount transmitted.

Certificate of Medical Necessity (CMN)

Providers who submit claims electronically gain access to additional functions such as CMNs. For certain items or services billed to the DMERC, the supplier must receive a signed Certificate of Medical Necessity (CMN) from the treating physician. When CMNs are submitted electronically to the DMERC, only information in Sections A, B, and D of the CMN are required since the information in Section C cannot be transmitted electronically. However, suppliers who bill electronically are not exempt from completing Section C of the original CMN. Please refer to Chapter 5, Section 3.3, of the *Medicare Program Integrity Manual*, which is available at http://www.cms.hhs.gov/manuals/108_pim/pim83c05.pdf on the Web. The local DMERC should also be able to provide additional information regarding completion of CMNs.

CMNs may be used when submitting claims for ambulances, cataract glasses, chiropractor, Durable Medical Equipment (DME), oxygen, and certain types of podiatry services.

Note: CMNs are not necessary for every claim and, if necessary, are not always required with the initial claim submission. The local carrier can provide additional information.

However, this report will also list the claims that were rejected, as well as the reason(s) for being rejected. At this point, the provider can make the necessary corrections to the claim(s) and resubmit them immediately.

The following are alternatives for electronically submitting claims data:

- ❖ Providers may work through a software vendor who can provide the level of practice management system support needed for the provider's practice setting;

- ❖ Providers may submit their Medicare claims directly to the payment contractor or choose to submit claims through a clearinghouse;
- ❖ Providers may choose to have a billing agent handle all or part of the Medicare billing; or
- ❖ If the provider's office has the required hardware, they may choose to use Medicare's free billing software.

Additional EMC Benefits

In addition to the day-to-day benefits of EMC, other features are available to electronic filers:

- ❖ **Eligibility Access:** Participating providers who file claims electronically may acquire access to beneficiary eligibility files through their vendor. The provider can determine if a patient is eligible for Medicare benefits, has met the Medicare deductible, is enrolled in a Health Maintenance Organization (HMO), or is entitled to Medicare where Medicare is the secondary payer.
- ❖ **Electronic Remittance Notification (ERN):** An EMC provider can receive paid and/or denied claims information electronically from the Medicare Part B system. ERN may be used to automatically update provider accounts receivable files or the patient billing system. ERN is the equivalent of the Medicare Remittance Notice (MRN) form and can eliminate the need to manually post payments.
- ❖ **Electronic Claims Status (ECS):** EMC providers may obtain a paper or electronic list of all Medicare pending claims 14 days or older for tracking and monitoring.
- ❖ **Electronic Funds Transfer (EFT):** With EFT, Medicare Part B can send payments directly to a provider's financial institution whether claims are filed through EMC or on paper.

HOW TO APPLY FOR EMC SUBMISSION

To submit an Electronic Media Claims (EMC) claim using EDI in HIPAA format, the CMS Standard EDI Enrollment Form must be completed prior to submitting the EMC to Medicare. This form must be submitted by each physician, supplier, or group that intends to submit an EMC. Each new EMC biller must sign the form and submit it to his or her local Medicare carrier or DMERC. In addition, any existing EMC billers who have not completed the CMS Standard EDI Enrollment Form must also complete and sign this form and submit it to their local carrier or DMERC.

An organization comprised of multiple components that have been assigned Medicare provider numbers, supplier numbers, or Unique Physician Identification Numbers (UPINs) may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these numbers have been assigned. The organization as a whole is to be held responsible for the performance of its individual components.



Local Carrier and DMERC Help Lines

A list of local carrier and DMERC EDI Help Lines is available at

<http://www.cms.hhs.gov/providers/edi/bnum.asp> on the Web.

CMS EDI Standard Enrollment Form

Additional information regarding the CMS Standard EDI Enrollment Form is available at <http://www.cms.hhs.gov/providers/edi/edi5.asp> on the Web.

An electronic copy of the CMS Standard EDI Enrollment Form in Portable Document Format (PDF) is available at <http://www.cms.hhs.gov/providers/edi/ediagree.pdf> on the Web.

HIPAA Compliance Code Sets

If submitting electronically, the following medical code sets apply:

- ❖ ICD-9-CM (Volumes 1 & 2) - used to indicate diseases, injuries, impairments, or other health problems and their manifestations. Also used to indicate causes of injury, disease, impairment, or other health problems; or
- ❖ ICD-9-CM (Volume 3) - used to indicate prevention, diagnosis, treatment, and management of a disease; or
- ❖ National Drug Codes (NDC) - used to indicate drugs and biologics used on retail pharmacy transactions; or
- ❖ Current Dental Terminology (CDT) - used to indicate American Dental Association (ADA) services; or
- ❖ HCPCS and Current Procedural Terminology (CPT)-4 - used to indicate physician and other health care services to include physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory tests, medical diagnostic services, hearing and vision services, and transportation services (including ambulance); or
- ❖ HCPCS - used to indicate equipment, supplies, or other items used in health care services to include supplies such as medical supplies, orthotic and prosthetic devices, or DME.

Important Note: The National Correct Coding Initiative (NCCI) pertains specifically to HCPCS and CPT codes and helps physicians to correctly code claims submissions by providing the most recently edited code information. All physicians should access this information at <http://www.cms.hhs.gov/physicians/cccredits/> on the Web.

SUBMITTING PAPER CLAIMS

Today, only a limited number of providers are permitted to submit paper claims. **After October 16, 2003**, providers who are not a small provider (institutional organizations with 25 or less full-time employees or physicians and suppliers with 10 or less full-time employees) must submit all claims via EDI in HIPAA format. In addition, unlike EMC claims that can be paid within 14 days, paper claims cannot be paid until 28 days after the payment contractor has received a “clean” (i.e., error-free) claim. Before submitting paper claims, providers should contact their carrier to identify the most effective options for submitting such claims. In addition, when submitting a claim to Medicare for tertiary payment (i.e., there is more than one primary payer), these claims must be submitted in paper hardcopy to Medicare.



Submitting a “Black and White” Form CMS-1500

There are some carriers who will accept “black and white” copies of Form CMS-1500, and copies containing handwritten instead of typed entries. If a carrier does accept such a form, the provider may not be required to submit the back side of the form if a signed attestation statement is filed with the carrier on an annual basis. This statement should say, “...he or she has read the reverse side of Form CMS-1500 and understands the requirements and agrees to comply with applicable Medicare billing requirements.” These options vary by carrier.

HOW PAPER CLAIM SUBMISSION WORKS

Some payment contractors process claims using Optical Character Recognition (OCR), an automated scanning process similar to scanners that read price labels in grocery stores. OCR claims processing is faster and more accurate than systems requiring manual input. However, to work properly, OCR must accurately read and

interpret the characters entered in each field. It reads only typed or machine-printed data. If a carrier uses OCR software for automated claims processing, only an original, red and white Form CMS-1500 may be submitted.

After the claims information is scanned, it is transmitted to the claims processing system where it is validated and compared to other data until final processing occurs.

To ensure quick and accurate claim processing, the following guidelines should be followed:

- ❖ Do not staple, clip, or tape anything to the Form CMS-1500.
- ❖ Place all necessary documentation in the envelope with the Form CMS-1500.
- ❖ Put the patient's name and Medicare number on each piece of documentation submitted.
- ❖ Use dark ink.
- ❖ Use only upper-case (CAPITAL) letters.
- ❖ Use 10 or 12 pitch (pica) characters and standard dot matrix fonts.
- ❖ Do not mix character fonts on the same form.
- ❖ Do not use italics or script.
- ❖ Avoid using old or worn print bands or ribbons.
- ❖ Do not use dollar signs, decimals, or punctuation.
- ❖ Enter all information on the same horizontal plane within the designated field.
- ❖ Do not print, hand-write, or stamp any extraneous data on the form.
- ❖ Use only lift-off correction tape to make corrections.
- ❖ Ensure data is in the appropriate field and does not overlap into other fields.
- ❖ Remove pin-fed edges at side perforations.
- ❖ Use only an original red-ink-on-white-paper Form CMS-1500 (12-90) claim form.



Form CMS-1500 Claim Form Information

Providers can view information regarding paper claims filing and download copies of claim forms at <http://www.cms.hhs.gov/providers/edi/edi5.asp> on the Web.

Official red-printed Form CMS-1500s are available for purchase from various vendors. They are also available in various formats from the U.S. Government Printing Office (GPO). Negatives are also available from the GPO. Contact the GPO at 1-866-512-1800 or mail publication order inquiries to:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, Pennsylvania 15250-7954

Providers can also contact the GPO for printing information at <http://bookstore.gpo.gov> on the Web.

WHAT IS A REMITTANCE ADVICE (RA)?

After Medicare processes a claim, a RA is sent to the provider. The RA can take the form of a Standard Paper Remittance (SPR) Advice Notice or an Electronic Remittance Advice (ERA).

The SPR format corresponds to the ERA format. The ERA format is the HIPAA standard format, also known as ASC X12 Transaction 835 (Healthcare Claim Payment/Advice) version 4010A1. This standard format is also referred to as the "Transaction 835". The Transaction 835 is intended to meet the particular needs of the healthcare industry for the payment of claims and the transfer of remittance information.

The Transaction 835 contains Health Care Claim Adjustment Reason Codes and RA Remark Codes. Health Care Claim Adjustment Reason

Code and RA Remark Code sets have been adopted under HIPAA as the standard code sets to be used in the standard Transaction 835. These codes are key elements for providing detailed payment adjustment information relative to a healthcare claim(s). If applicable, these codes also describe why the total original charges have not been paid in full.

Health Care Claim Adjustment Reason Codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no Health Care Claim Adjustment Reason Code. Under HIPAA, it is important to understand the term "adjusted". Adjusted indicates that there is a denied payment, zero payment, partial payment, reduced payment, penalty applied, additional payment, or supplemental payment.

RA Remark Codes are used within the Transaction 835 to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Health Care Claim Adjustment Reason Code. An RA Remark Code may be used at either the claim or service line level if it is appropriate for the specific situation. Use of an RA Remark Code at the claim level conveys information about claim level adjustments or about the overall processing of the claim. Use of RA Remark Codes at the line level conveys information about adjustments for the specific service line or about the processing of those services. Since RA Remark Codes provide information about remittance processing or further explain an adjustment, RA Remark Codes will seldom be used unless there is an adjustment to report.

Lastly, it is important to understand the difference between a Health Care Claim Adjustment Reason Code and an RA Remark Code. Health Care Claim Adjustment Reason Codes explain an adjustment (an amount paid that is different than the amount billed, including a zero payment or a denial) to the amount submitted by the provider. RA Remark Codes accomplish two

purposes. They convey informational messages about general remittance practices or they provide a supplemental explanation for an adjustment already described by a Health Care Claim Adjustment Reason Code. It is important to review the Health Care Claim Adjustment Reason Codes and the RA Remark Codes, along with other information regarding the Transaction 835. The codes help the biller understand the specific business reason for any denial or reduction in payment before making an inquiry to Medicare.



RA Code Information

The most current code list and a description of Health Care Claim Adjustment Reason Codes and RA Remark Codes can be found at <http://www.wpc-edi.com/codes/Codes.asp> on the Web. These code lists are updated three times a year and posted during May, July, and November. See Reference F for a list of approved Health Care Claim Adjustment Reason Codes per the most recently posted update at the time of printing. See Reference G for a list of RA Remark Codes per the most recently posted update at the time of printing.

In addition to this notice, Medicare notifies the beneficiary using a Medicare Summary Notice. The format of notification that the beneficiary receives depends on the carrier or DMERC processing the claim.

If the provider receives an RA electronically, he or she must be ready to receive the notice in HIPAA standard format (ASC X12N Transaction 835 version 4010A1) by October 16, 2003.

ARE THERE ANY SPECIAL CONSIDERATIONS WHEN SUBMITTING CLAIMS?

Depending on the specialty of the Part B provider, there are additional special considerations a biller will be involved in when submitting claims. These considerations include:

- ❖ Deciding whether to accept assignment;
- ❖ Determining whether Medicare should be billed first;
- ❖ Submitting Certificates of Medical Necessity (CMNs);
- ❖ Providing Advance Beneficiary Notices (ABNs);
- ❖ Providing Notices of Medicare Benefits (NEMBs); and
- ❖ Deciding whether to submit additional documentation with the initial claim.

ACCEPTING OR NOT ACCEPTING ASSIGNMENT

Certain Part B providers must always accept Medicare payments while other physicians, practitioners, and suppliers may choose to enter into a participating agreement. Carriers who are “participating providers” are paid at 100% of the physician Fee Schedule and must accept assignment. This means that they must accept Medicare payment as payment in full, except for any unmet deductible and coinsurance that would be the patient's responsibility.

However, “non-participating providers” are paid at 95% of the fee schedule (less deductible and coinsurance) and may accept assignment on a claim-by-claim basis. Beneficiary liability for coinsurance of non-participating providers varies by type of provider service, and the provider may be subject to a limiting charge.

Also, regardless of participation, some suppliers and practitioner types are required to accept assignment. See Part 2, Common Provider Enrollment Questions, for additional information

regarding assignment, participation, and non-participation.

All physicians and suppliers are required to file claims with carriers and DMERCs on behalf of all beneficiaries within one year from the date of service per the Omnibus Budget Reconciliation Act (OBRA) of 1989. Regardless of the type of claim, providers may never charge Medicare patients for completing or filing a claim. Proper completion and submission of a “clean” (i.e., error-free) Medicare claim is the first step in accurate claims processing. Clean claims are claims that successfully process without system-generated requests for additional information.

SUBMITTING ASSIGNED CLAIMS

Either a participating or a non-participating Part B provider may file assigned claims for any Part B claim. The provider is held to the assignment agreement for that claim only and agrees to accept the Medicare fee schedule amount as payment in full for all covered services. The provider is reimbursed directly. To accept assignment of Medicare benefits for a claim, the Part B provider must check “Yes” in Item 27 on Form CMS-1500 (see Figure 3-2). Providers may collect reimbursement for excluded services, unmet deductible(s), and coinsurance amounts from the beneficiary.

Figure 3-2. Check “Yes” to Accept Assignment.

The image shows a portion of the CMS-1500 form. A red circle highlights item 27, "ACCEPT ASSIGNMENT? (For govt. claims, see back)". The "YES" checkbox is checked, and the "NO" checkbox is unchecked. The form includes various fields for patient information, dates of service, diagnosis codes, and charges.

Assignment is mandatory for the following claims:

- ❖ Clinical diagnostic laboratory services and physician laboratory services;

- ❖ Physician services to individuals dually entitled to Medicare and Medicaid;
- ❖ Services of physician assistants (PAs), advanced registered nurse practitioners (ARNPs), clinical nurse specialists (CNSs), nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and medical nutritional therapists;
- ❖ Ambulatory Surgical Center (ASC) services;
- ❖ Home dialysis supplies and equipment paid under Method II;
- ❖ Drugs; and
- ❖ Ambulance services.

For practitioner services of physicians, and services of independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Acceptance of assignment is also not mandatory for suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may voluntarily agree to participate in taking advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement.

SUBMITTING NON-ASSIGNED CLAIMS

Only a non-participating provider may file non-assigned claims. A non-participating provider does not agree to accept Medicare's allowed amount as payment in full and may charge the beneficiary or the service(s) up to the limiting charge. The limiting charge is the maximum amount that a non-participating provider may charge the beneficiary.

The limiting charge applies to all of the following services/supplies, regardless of who provides or bills for them:

- ❖ Physicians' services;
- ❖ Services and supplies furnished incidental to physician's services that are commonly furnished in a physician's office;
- ❖ Outpatient physical and occupational therapy (OT) services furnished by an independently practicing therapist;

- ❖ Diagnostic tests; and
- ❖ Radiation therapy service, including X-ray, radium, and radioactive isotope therapy, materials, and technician services.

The limiting charge is 115% of the Fee Schedule amount.

Example of a Limiting Charge

Medicare Fee Schedule allowed amount = \$200.00
 Non-participating provider allowed amount = \$190.00 (95% of \$200)
 Limiting charge = \$218.50 (\$190 x 1.15)
 Maximum beneficiary coinsurance to non-participating provider = \$28.50 (\$218.50 - \$190.00)

Note: The limiting charge provision does not apply to certain equipment and supplies. Please contact the carrier for details. Limiting charge provisions also do not apply when Medicare is secondary to another insurance. A non-participating provider may round the limiting charge to the nearest dollar if done consistently for all services.

When a non-participating provider files a Part B non-assigned claim, the beneficiary is reimbursed directly. To refuse assignment of Medicare benefits for a claim, the provider must check “No” in Item 27 of Form CMS-1500 (see Figure 3-3).

Figure 3-3. Check “No” to Refuse Assignment.

The image shows a portion of the CMS-1500 form. Item 27, 'ACCEPT ASSIGNMENT? (For govt. claims, see back)', is circled in red. The 'NO' option is checked with a red 'X'. The 'YES' option is unchecked. The form also includes fields for patient information, diagnosis codes, charges, and provider details.

SUBMITTING MEDICARE SECONDARY PAYER (MSP) CLAIMS

Medicare Secondary Payer (MSP) is the term used when Medicare is not responsible for making the primary payment on beneficiary health care claims. All healthcare providers and suppliers are required to determine, prior to billing, whether Medicare is the primary or secondary payer. Medicare becomes the secondary payer when other primary insurance exists.

MSP REGULATIONS

Until 1980, the Medicare program was the primary payer in all situations except those involving Workers' Compensation (WC) (including Federal Black Lung) benefits. Since 1980, changes in the Medicare law have resulted in Medicare being the secondary payer in other situations. The MSP program protects Medicare funds and ensures that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage.

MEDICARE COORDINATION OF BENEFITS (COB) CONTRACT

In November 1999, CMS embarked on an important initiative to expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program by awarding the COB contract. The COB initiative to consolidate activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries became effective as of April 2000.

The purpose of the COB program is to identify health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent and minimize overpayments of Medicare benefits. Information on eligibility

and benefits entitlement is obtained from the COB central file and is used to facilitate accurate payment.

The COB program provides many benefits for employers, providers, physicians, suppliers, third-party payers, attorneys, beneficiaries, and Federal and State programs. All MSP claim investigations are initiated and researched by the COB contractor, not by the local Medicare FI or carrier. This one-step approach minimizes the number of duplicate MSP investigations. It offers a centralized, one-stop customer service approach for all MSP-related inquiries, including those on general MSP information (but not related to specific claims or recoveries that serve to protect the Medicare Trust Fund). The COB contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys, or other beneficiary representatives, employers, insurers, providers, physicians, suppliers, and other health plans.

A variety of methods and programs is used by the COB contractor to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. FIs and carriers will continue to process claims submitted for primary or secondary payment. Claim processing is not a function of the COB contractor.



MSP Inquiries

Refer all MSP inquiries to the COB contractor at 1-800-999-1118 or TDD/TTY 1-800-318-8782.

Contact the local FI and/or carrier regarding claims and/or recovery-related questions.

Note: All possible insurers must be identified. There may be situations in which more than one insurer is primary to Medicare (e.g., liability or no-fault insurer, GHP).

BENEFITS OF THE MSP PROGRAM

The successful implementation of the MSP Program has resulted in positive benefits for Medicare, providers, suppliers, and the patient. Benefits include the following:

- ❖ National program savings - Claims are paid by insurers that are primary to Medicare, resulting in a national program savings in excess of \$4 billion dollars annually.
- ❖ Increased revenue - A provider or supplier that bills a liability insurer is entitled to pursue full charges. Receiving more favorable reimbursement is to the advantage of the provider or supplier. In many instances, insurance companies that are primary will pay the entire amount billed, rather than only the amount authorized under Medicare.
- ❖ Lower out-of-pocket expenses - Multiple insurance coverages often reduce the amount a patient is obligated to pay, which includes satisfying deductible amounts and preserving Medicare coverage limits.

WHEN MEDICARE IS CONSIDERED SECONDARY

The MSP law makes Medicare the secondary payer to insurance plans and programs under certain conditions. Three provisions of the MSP law require Medicare to be secondary payer related to GHPs. These provisions are working-aged, end-stage renal disease (ESRD), and disability. Other provisions of the MSP law require Medicare to be secondary payer relating to disease or accidents as a result of employment or coverage available under WC, liability, or no-fault insurance.

In addition, services authorized under the Veterans Health Administration (VHA) and other government programs such as research grants are primary to Medicare even though they are not specific MSP provisions.

When Medicare is the secondary payer, the other payer pays first and Medicare pays second. A brief description of situations in which MSP billing applies follows:

❖ **Services Payable Under GHP Benefits**

Working-Aged - Medicare benefits are secondary to benefits payable under a GHP for individuals age 65 or over who have GHP coverage as a result of their own current employment status or the current employment status of a spouse of any age. Specific conditions when this applies:

- ❖ MSP requires employers of 20 or more employees to offer their “working-aged” employees and their

- spouses age 65 and over the same GHP offered to other employees.
- ❖ Medicare is the secondary payer to a GHP when a single employer with 20 or more employees (as determined by the IRS) sponsors or contributes to the GHP, or when multiple employers sponsor or contribute to the GHP and at least one of them has 20 or more employees.

ESRD - Medicare benefits are secondary to benefits payable under a GHP for individuals under age 65 who are eligible for, or entitled to, Medicare based on ESRD during a Medicare coordination period, as described in Table 3-1. Specific conditions when this applies:

Table 3-1. Stages of End-Stage Renal Disease Coverage (ESRD) Under a Group Health Plan (GHP).

Stage	Timeframe	What Happens:
Stage 1 Waiting Period for Eligibility	Three months from the first day of dialysis.	If GHP coverage is available, the GHP is primary and there is no Medicare coverage during the waiting period.
Stage 2 Coordination Period	<p>Begins with eligibility/entitlement for Medicare based on ESRD.</p> <p>For eligibility/entitlement beginning prior to 3/1/96, Coordination Period lasts 18 months.</p> <p>For eligibility/entitlement periods beginning on or after 3/1/96, Coordination Period lasts 30 months.</p>	GHP is primary and Medicare is secondary.
Stage 3 Primary Medicare Benefits	After Coordination Period, and until Stage 4 occurs.	Medicare is primary and GHP is secondary.
Stage 4 End of Medicare Benefit	<p>When patient has ceased dialysis treatments for 12 months.</p> <p>OR</p> <p>36 months after successful kidney transplant.</p>	Only GHP coverage is available.

ESRD Information

Medicare entitlement can start earlier in some cases where the beneficiary received a kidney transplant, or is taking part in a home dialysis training program and expects to complete the training period within the first three months of dialysis. There is a separate coordination period each time a beneficiary becomes eligible for Medicare based on kidney failure. Entitlement can be resumed without a waiting period. For additional information, see the publication entitled *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* available at <http://www.medicare.gov/Publications/Pubs/pdf/10128.pdf> on the Web. If a GHP does not pay the entire charge for items or services furnished to a beneficiary, Medicare will make secondary payments, taking into account:

- ❖ The amount the GHP has allowed; and
- ❖ The amount Medicare considers reasonable for those items or services.

If the GHP provides no benefits at all for particular medically necessary services (e.g., a kidney transplant), Medicare may pay for those services as primary payer, assuming the services are covered under Medicare.

- ❖ Persons with ESRD who can receive secondary Medicare are beneficiaries also covered by a GHP or beneficiaries who are the family members of someone covered by a GHP.

Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP) -

Medicare benefits are secondary to benefits provided by GHPs for certain disabled individuals under age 65 who have coverage based on their own current employment status or the current employment status of a family member.

Specific conditions when this applies:

- ❖ Persons who can receive secondary Medicare due to disability are disabled beneficiaries covered by an LGHP (100 or more employees), or they are a family member of someone who is covered by an LGHP.

❖ Services Related to Liability or No-Fault Insurance Coverage or Employment Related Disease or Accidents

Liability or No-Fault Insurance - Medicare benefits are secondary to payments that have been issued, or can reasonably expect to be made promptly for items or services under liability or no-fault insurance.

Medicare is secondary to liability or no-fault insurance even if state law or a private contract of insurance stipulates that its benefits are secondary benefits, or otherwise limits payments to Medicare beneficiaries.

Employment Related Disease or

Accidents - Medicare is secondary payer to WC plans (including Federal Black Lung benefit programs). Payment under Medicare may not be made for any items or services if payment has been made, or can reasonably be expected to be made under a WC law or plan. If services are furnished that are not payable by WC, then Medicare is primary payer for those services.

❖ Other Services Where MSP Provisions Apply

VHA - The VHA pays for health care services rendered (usually at VHA facilities) to persons who have served in the armed forces. When the VHA is unable to provide services at one of its facilities, they may authorize non-Federal providers and suppliers to do so at Federal expense. When VHA authorized items or services are provided at a non-Federal facility, Medicare does not make payment for such

items or services. Details about the VHA payment policy are provided within the *Medicare Benefit Policy Manual*, Chapter 16, §50.1, which is available at http://www.cms.hhs.gov/manuals/102_policy/bp102c16.pdf on the Web.

Note: Eligibility coverage may change during a course of treatment. Providers and suppliers are required to query Medicare patients to determine if any of these MSP conditions apply.

Table 3-2 lists some common situations when Medicare is the primary and secondary payer.

MSP INFORMATION THAT PROVIDERS OR SUPPLIERS SHOULD OBTAIN FROM A BENEFICIARY OR REPRESENTATIVE

Providers and suppliers are required by law to collect information from beneficiaries regarding the availability of other health insurance related to the items or services included on the claim. In addition, Medicare regulations require that providers and suppliers must agree “to bill other primary payers before billing Medicare”¹. Thus, any provider that bills Medicare for items and services must determine whether or not Medicare is the primary payer. This must be accomplished by asking beneficiaries, or their representatives,

Table 3-2. List of Common Situations When Medicare May Pay First or Second.

If the patient...	And this condition exist...	Then this program pays first...	And this program pays second...
Is age 65 or older, and is covered by a General Health Plan (GHP) through a current employer...	The employer has less than 20 employees...	Medicare	GHP
	The employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals...	GHP	Medicare
Has an employer retirement plan and is age 65 or older, or disabled and age 65 or older...	The patient is entitled to Medicare...	Medicare	Retiree coverage
Is disabled and covered by a Large Group Health Plan (LGHP) from work, or from a family member who is working...	The employer has less than 100 employees...	Medicare	GHP
	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	LGHP	Medicare
Has end-stage renal disease (ESRD) and GHP coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	GHP	Medicare
	After 30 months...	Medicare	GHP

¹42 CFR489.20(g)

If the patient...	And this condition exist...	Then this program pays first...	And this program pays second...
Has ESRD and COBRA coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	Medicare
	After 30 months...	Medicare	COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury...	The patient is entitled to Medicare...	WC (for health care items or services related to job-related illness or injury)	Medicare
Has black lung disease and is covered under the Federal Black Lung Program...	The patient is eligible for the Federal Black Lung Program...	Federal Black Lung Program (for healthcare services related to black lung disease)	Medicare
Has been in an accident where no-fault or liability insurance is involved...	The patient is entitled to Medicare...	No-fault or liability insurance (for accident related health care services)	Medicare
Is age 65 or older OR is disabled and covered by Medicare and COBRA...	The patient is entitled to Medicare...	Medicare	COBRA
Has Veterans Health Administration (VHA) benefits...	Receives VHA authorized health care services at a non-VHA facility...	VHA	Medicare may pay when the services provided are Medicare covered services and are not covered by the VHA

questions concerning the beneficiary's MSP status. If providers fail to provide correct and accurate claims with Medicare, regulations permit Medicare to recover its conditional payments to them.

COLLECTING BENEFICIARY MSP INFORMATION

Generally, Medicare policy requires providers to update beneficiary MSP information for every admission, outpatient encounter, or start of care prior to submitting a bill to Medicare. However, there are some exceptions.

When COBRA Applies

COBRA is a law that requires employers with 20 or more employees to allow employees and their dependents to keep their group health coverage for a time after they leave their GHP. This is called continuation coverage and can last up to 18, 29, or 36 months in some cases. COBRA and Medicare interact as follows:

- ❖ If the beneficiary or spouse are age 65 or over and have COBRA, Medicare is the primary payer.
- ❖ If the beneficiary or family member has Medicare based on disability and has COBRA, Medicare is the primary payer.
- ❖ If the beneficiary or family member has Medicare based on ESRD, COBRA is the primary payer for a 30-month period and Medicare is secondary.

Set-Aside Arrangements for WC Settlements

Medicare may remain the secondary payer even after a WC settlement. If a WC settlement includes compensation for future treatment of medical conditions related to the work-related illness or injury, and CMS approved the amounts that were set-aside to consider Medicare's interests, then those amounts are referred to as a set-aside arrangement.

In these situations, providers and suppliers would only bill the set-aside account. Once the set-aside account is depleted, Medicare becomes primary. The beneficiary's set-aside balance can be checked by contacting the carrier or administrator of the set-aside arrangement.



Billing Requirement Exceptions

For additional information regarding those exceptions, refer to Chapter 3, MSP Provider Billing

Requirements, of the *Medicare Secondary Payer (MSP) Manual*, which is available at http://www.cms.hhs.gov/manuals/105_msp/msp105c03.pdf on the Web.

SPECIFIC BENEFICIARY MSP INFORMATION THAT MUST BE COLLECTED

The questionnaire provided within Reference D contains questions that should be asked of Medicare beneficiaries upon each start of care. Providers can use this questionnaire as a guide to help identify other payers that may be primary to Medicare. Starting with Part 1 of the questionnaire, the provider should ask the patient each question in sequence. By following the instructions included on the questionnaire, the provider will be able to identify who should pay first.

ONLINE VERIFICATION OF MSP INFORMATION

Providers with online capability may now access the following MSP information via the Common Working File (CWF) MSP auxiliary file:

- ❖ MSP effective date;
- ❖ MSP termination date;
- ❖ Patient relationship;
- ❖ Subscriber name;
- ❖ Subscriber policy number;
- ❖ Insurer type;
- ❖ Insurer information to include name, group number, address, city, state, and ZIP code;
- ❖ MSP type;
- ❖ Remarks code;
- ❖ Employer information to include name, address, city, state, and ZIP code; and
- ❖ Employee data to include ID number.

At the provider's discretion, these data may be viewed during either the admission or the billing process. However, the data must be viewed before the bill is submitted to Medicare. If used during admission, the provider can verify the

accuracy of each data element using the questions found in the questionnaire provided within Reference D (see Part III, Specific Beneficiary MSP Information that Must be Collected).

RETENTION REQUIREMENTS FOR MSP DOCUMENTATION

The provider should retain a copy of the completed admission questionnaires on-file or online for audit purposes. This demonstrates that the provider has investigated with the beneficiary to determine if there is other primary payer coverage. The beneficiary does not need to sign the forms. It is prudent for providers to retain these records for 10 years in a paper, optical image, microfilm or microfiche, or online format.

SUBMITTING AN MSP CLAIM

Specific instructions for submitting MSP claims are included in Chapter 3, MSP Provider Billing Requirements, of the *Medicare Secondary Payer Manual*.



Instructions for Submitting MSP Claims

The *Medicare Secondary Payer Manual* containing instructions for submitting MSP Claims is available at http://www.cms.hhs.gov/manuals/105_msp/msp105index.asp on the Web.

WHEN MEDICARE PAYS FIRST IN AN MSP SITUATION

Medicare will pay first in an MSP situation called “Conditional Primary Medicare Benefits”. There is frequently a long delay between occurrence of an injury and the decision by the State WC agency in cases where compensability is being contested or is in a comparative liability action. A denial of Medicare benefits pending outcome of the final decision means that beneficiaries might be required to advance their own funds to pay for expenses that are eventually borne by WC, the

liability insurer, the no-fault insurer, or Medicare. To avoid imposing hardship on Medicare beneficiaries pending such decision, conditional Medicare payments may be made. Such payments are conditional upon reimbursement to the Medicare Trust Fund if it is later determined that the services are covered by WC, the no-fault insurer, or the liability insurer. Conditional payments may also be paid for services denied in limited situations.

Conditional primary Medicare benefits may be paid if the beneficiary, provider, physician or supplier has filed a proper claim with the applicable primary insurer (state WC, liability, and/or no-fault plan), and:

- ❖ Payments expected from the applicable plans are not paid promptly (i.e., within 120 days of receipt of the claim at a minimum) for any reason except when the plan claims that its benefits are secondary to Medicare; or
- ❖ The properly submitted claim was denied in whole or in part; or
- ❖ Because of physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer.

When such conditional Medicare payments are made, they are made on the condition that both the insurer and beneficiary will reimburse the program to the extent that payment is subsequently made by the insurer.



MSP Patient and Staff Education

A plain language MSP publication for patient and staff education entitled *Medicare and Other Health Benefits: Your Guide to Who Pays First* is available at <http://www.medicare.gov/Publications/Home.asp> on the Web.



Additional MSP Information

Additional MSP information can be obtained from the following resources:

- ❖ The *Medicare Secondary Payer (MSP) Provider Billing Requirements Manual* available at http://www.cms.hhs.gov/manuals/105_msp/msp105index.asp on the Web;
- ❖ The Medicare COB contractor at 1-800-999-1118;
- ❖ The carrier who can answer questions pertaining to claims-related information;
- ❖ Frequently Asked Questions (FAQs) available at <http://www.cms.hhs.gov/> on the Web. Click the FAQs option on the top toolbar to access the FAQ page. When at the FAQ page, click to access the “Topics” drop-down menu. Choose the “Coordination of Benefits” or “Medicare Secondary Payer” option, then click on the “Search” button to find all related questions; and
- ❖ An e-mail address that can be used to submit MSP questions and comments to CMS at mspcentral@cms.hhs.gov.

DISCONTINUING SERVICES

In many situations where providers must discontinue or deny services, the patient has a right to receive written notification as to the reason the services are no longer going to be furnished or expected to be paid for by Medicare.

PROVIDING AN ADVANCE BENEFICIARY NOTICE (ABN)

Whenever a provider believes that the service/item he or she is providing may not be covered by Medicare as medically reasonable and necessary or one of several other denial reasons (see Note below), he or she should



Written Advance Notice Information

Additional information regarding providing written advanced notice to patients that Medicare may not or will not pay for the services suggested by the providers can be found at <http://www.cms.hhs.gov/medicare/bni/> on the Web.

provide the patient with an acceptable ABN of Medicare's likely denial of payment. If the provider does not provide the patient with an ABN, it generally cannot hold the patient financially liable for the service/item if Medicare denies payment. Patients must be notified that payment might be denied or reduced before the service is rendered. The patient may then decide if he or she wants the service and is willing to pay for it. If the provider properly notifies the patient in advance that payment for the service may be denied or reduced, the provider is not held financially liable for the services and may seek payment from the patient if Medicare denies payment.

Note: Financial Liability Protections (FLPs) apply solely to denials of Medicare payment on the basis of one of the statutory exclusions that, by law, trigger FLPs. Following is the complete list of exclusions that trigger FLPs and require an ABN:

- ❖ §1862(a)(1) - “medical necessity” exclusion denials per Limitation on Liability (LOL) §1879(a)-(g) and per Refund Requirement (RR) §1842(l) and §1834(j)(4).
- ❖ §1862(a)(9) - “custodial care” exclusion denials - per LOL §1879(a)-(g).
- ❖ §1814(a)(2)(C) and §1835(a)(2)(A) - homebound and intermittent home health care denials - per LOL §1879(g)(1).
- ❖ §1861(dd)(3)(A) - denials because the beneficiary in hospice is found not to be terminally ill - per LOL §1879(g)(2).

- ❖ §1834(a)(17)FIRST(B) - prohibited telephone solicitations (“cold calls”) DME denials - per RR.
- ❖ §1834(j)(1) - failure to have a supplier number DMEPOS denials - per RR.
- ❖ §1834(a)(15) - payment denied in advance (advance coverage determination) DME denials - per RR.

The following ABN notice forms are approved by CMS:

- ❖ Advance Beneficiary Notice (Form CMS-R-131);
- ❖ Home Health Advance Beneficiary Notice (HHABN) (Form CMS-R-296);
- ❖ Hospital-Issued Notice of Non-Coverage (HINN) (Form CMS-10092); and
- ❖ SNF Notice of Non-Coverage (NONC) (Form CMS-10055).



Beneficiaries Notification Initiative Information

Information about the Beneficiaries Notification Initiative

and all of the current ABN forms can be accessed at <http://www.cms.hhs.gov/medicare/bni> on the Web.

Instructions for Completing ABNs

The Medicare program instructions for ABNs are included within Chapter 30 of the *Medicare Claims Processing Manual*, available at http://www.cms.hhs.gov/manuals/104_claims/clm104c30.pdf on the Web.

SPECIFIC CRITERIA FOR THE ABN

An acceptable ABN for the denial or reduction of payment must meet the following criteria:

- ❖ The notice must be given in writing, in advance of providing the service/item (where a standard form is mandatory, notice must be given using the standard form);

- ❖ The notice must include the patient's name, description of service/item, and reason(s) the service/item may not be paid for by Medicare; and
- ❖ The patient or authorized representative must sign and date the ABN before a service is rendered, indicating that the patient assumes financial liability for the service/item if payment is denied or reduced for the reasons indicated on the ABN.

ABN FOR SERVICES PROVIDED PER REFERRAL OR ORDER OF ANOTHER PHYSICIAN

Providers must be aware of the coverage requirements for the services they provide (if they have been made available) to a patient based on a referral or order of a physician. In most cases, the availability of the coverage requirements indicates that the provider knew, or should have known, that payment for the item/service might be denied or reduced.

For services ordered by another physician (e.g., diagnostic tests), the provider who ordered the services may provide the ABN, but is not required to do so. The provider actually furnishing the services is responsible for beneficiary notification and can be held financially liable for the services if payment is denied or reduced. Also, the provider furnishing the services may be required to produce a copy of the ABN. In addition, if the ABN is considered unacceptable, the provider furnishing the services will be financially liable for those services.

For services provided based on the referral of a physician, the provider furnishing the service is in the best position to determine the likelihood of denial or reduction of payment and, therefore, should provide a proper ABN to the patient.

ABN MODIFIERS

Modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily not covered or do not meet the definition of a Medicare benefit, and items and services not considered reasonable

and necessary by Medicare. The modifiers are used for services billed and for items and supplies billed to DMERCs. Table 3-3 provides and describes the modifier codes used for both carrier and DMERC claims.

Assigned or non-assigned claims billed to Medicare Part B must contain the “GA” modifier next to each applicable service for which the proper ABN has been given to, and signed by, the patient. The ABN form does not need to be submitted with the claim, but a copy of the signed document must be maintained (e.g., within the patient’s medical records).

When DMERC claims are being filed, the “GA” and “GZ” modifiers should be used with the appropriate Healthcare Common Procedure Coding System (HCPCS) code whenever one is available. This alphanumeric code is used to describe the Durable Medical Equipment (DME) provided to the beneficiary. In cases where there is no specific HCPCS code available to describe the DME, the “A9270” HCPCS code must be used by suppliers to bill for statutorily not covered items and items that do not meet the definitions of a Medicare benefit.

**PROVIDING A NOTICE OF
EXCLUSIONS FROM MEDICARE
BENEFITS (NEMB) - FORM CMS-20007**

The NEMB may be used to advise beneficiaries that Medicare will not pay for particular items or services that are not Medicare benefits, before the items are furnished. NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions. Whenever it is inappropriate to use an ABN, the NEMB may be voluntarily used by physicians, practitioners, suppliers, and providers to advise their Medicare patients of the services that Medicare never covers.

Physicians, practitioners, suppliers, and providers may use notices of their own design, rather than use an already approved NEMB form. Some professional associations, with the assistance and approval of CMS, have developed service-specific NEMB-type notices to advise Medicare beneficiaries of the limits of Medicare coverage for certain items and



Latest HCPCS Codes
The most recently posted HCPCS codes are available at <http://www.cms.hhs.gov/medicare/hcpcs/default.asp> on the Web.



CMS-Approved NEMB Forms
NEMB forms that have been approved by CMS are accessible at <http://www.cms.hhs.gov/medicare/bni> on the Web.

Table 3-3. ABN Modifiers for Carrier or DMERC Claims.

Modifier	Explanation of Use
GA	Indicates that the physician, practitioner, or supplier expects Medicare to deny item or service and they do have an ABN signed by the beneficiary on file.
GY	Indicates that the physician, practitioner, or supplier deems the item or service to be statutorily excluded or not meeting the definition of any Medicare benefit, therefore it is non-covered or is not a Medicare benefit.
GZ	Indicates that the physician, practitioner, or supplier expects the item or service to be denied in a case where an ABN would be appropriate and they do not have an ABN signed by the beneficiary on file.

services. These service-specific notices are not government notices; they are considered proprietary notices of the authoring associations.

SPECIAL CONSIDERATIONS FOR SUBMITTING DME SUPPLIER CLAIMS TO A DMERC

DME is covered under Medicare Part B insurance and defined as equipment that can withstand repeated use, is primarily used for a medical purpose, and is generally not used in the absence of illness or injury. Suppliers submit DME claims to a DMERC who will process a DME claim based on a written order submitted by a supplier. Prior to submitting a claim to the DMERC, the supplier must have the written order and a CMN (if applicable), information from the treating physician concerning the patient's diagnosis (if an ICD-9-CM code is required on the claim), and any information required for the use of specific modifiers or attestation statements as defined in certain DMERC policies.

SUBMITTING WRITTEN ORDERS WITH DME CLAIMS

Written orders are acceptable for all transactions involving DME. Written orders can be submitted as a photocopy, facsimile image, electronic file, or an original "pen-and-ink" document. The supplier must obtain a written order that meets the requirements of this section. If the written order is for supplies that will be provided on a periodic basis, the written order should include:

- ❖ The start date of the order;
- ❖ A detailed description containing all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number;
Note: Someone other than the physician may complete the detailed description of the item or service. However, the treating physician must review the detailed description and

personally sign and date the order to indicate agreement.

- ❖ Appropriate information on the quantity used;
- ❖ Frequency of change;
- ❖ Indication of whether the order is a rented item, specifying the duration of need (if necessary); and
- ❖ The name of the drug, concentration level (if applicable), dosage, frequency of administration, and duration of infusion (if applicable) if the supply is a drug.

Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.) is NOT considered to be part of the order, although it may be included within the same document as the order.

A nurse practitioner or clinical nurse specialist may provide a verbal order, and then sign and date the subsequent written order in the following situations:

- ❖ He or she is treating the beneficiary for the condition for which the item is needed;
- ❖ He or she is practicing independently of a physician;
- ❖ He or she bills Medicare for other covered services using their own provider number; and
- ❖ He or she is permitted to do all of the above in the state in which services are provided.

A physician's assistant (PA) may provide a verbal order and then sign and date the subsequent written order if they satisfy the following requirements:

- ❖ He or she meets the Medicare definition of a PA (person with two or more years of advanced training who is exam-certified, works with a doctor, and can perform some of the services that a doctor can provide);
- ❖ He or she is treating the beneficiary for the condition for which the item is needed;
- ❖ He or she is practicing under the supervision of a Doctor of Medicine (DM) or Doctor of Osteopathy (DO);

- ❖ He or she has their own Unique Physician Identification Number (UPIN); and
- ❖ He or she is permitted to do all of the above in the state in which services are provided.



Example Written Order

An order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for one month, or until the ulcer heals.

SUBMITTING WRITTEN DME ORDERS PRIOR TO DELIVERY

A written order prior to delivery is required for the DME items that are listed with the associated HCPCS codes in Table 3-4.

For these items, the supplier must have received a written order that has been both signed and dated by the treating physician. The written order must meet the requirements specified in Part III, Submitting Written DME Orders Prior to Delivery.

If a supplier bills for an item without a written order when the supplier is required to have a written order prior to delivery, the item will be denied for not meeting the benefit category and therefore cannot be appealed by the supplier.

Table 3-4. DME Items with Associated HCPCS Codes.

HCPCS Code	Item
Decubitus Care	
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient
E0176	Air pressure pad or cushion, non-positioning
E0177	Water pressure pad or cushion, non-positioning
E0178	Gel pressure pad or cushion, non-positioning
E0179	Dry pressure pad or cushion, non-positioning (e.g., egg crate)
E0180	Pressure pad, alternating, with pump
E0181	Pressure pad, alternating, with pump, heavy duty
E0182	Pump for alternating pressure pad
E0184	Dry pressure mattress
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width
E0186	Air pressure mattress
E0187	Water pressure mattress
E0192	Low pressure and positioning equalization pad for wheelchair (for example, ROHO, Jay, etc.)
E0193	Powered air flotation bed (low air loss therapy)

HCPCS Code	Item
Decubitus Care (Con't)	
E0194	Air-fluidized bed
E0196	Gel pressure mattress
E0197	Air pressure pad for mattress, standard mattress length and width
E0198	Water pressure pad for mattress, standard mattress length and width
E0199	Dry pressure pad for mattress, standard mattress length and width
E0277	Powered pressure-reducing air mattress
E0371	Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
Seat Lift Mechanism	
E0627	Seat lift mechanism incorporated into a combination lift-chair mechanism
E0628	Separate seat lift mechanism for use with patient owned furniture-electric
E0629	Separate seat lift mechanism for use with patient owned furniture-non-electric
Transcutaneous Electrical nerve Stimulator (TENS)	
E0720	TENS, two-lead, localized stimulation
E0730	TENS, four-lead, larger area/multiple nerve stimulation
E0731	Form-fitting conductive garment for delivery of TENS or Neuromuscular Electrical Stimulator (NMES) (with conductive fibers separated from the patient's skin by layers of fabric)
Power Operated Vehicle (POV)	
E1230	Power operated vehicle (three-or four-wheel non-highway). Specify brand name and model number
Negative Pressure Wound Therapy (NPWT)	
K0538	Negative pressure wound therapy electrical pump, stationary or portable