
Essentials II

Spring 2006

April 18, 2006 - May 17, 2006

Program Education & Training
For Training Purposes Only

Disclaimers

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This seminar handout is meant as only an outline of the full seminar presentation. Additional information and discussion provided during the seminar will accompany these materials for a complete educational session. Use of these materials by entities other than HealthNow New York Inc. DMERC A may not fully reflect the educational intent for which they were developed.

Program Education & Training

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Agenda

- Supplier File Requirements
- Orders
- Certificate of Medical Necessity (CMN)
- Additional DMERC Forms
- Modifiers
- Advance Beneficiary Notice (ABN)
- Program Safeguard Contractor (PSC)
- Comprehensive Error Rate Testing (CERT)
- Resources

Supplier File Requirements

- CMN
- Physician Order
- Proof of Delivery
- Pick-Up Slip
- Description of Equipment
- Authorization
- Billing and Financial Records

Helpful Filing Hints

- Document all contacts
- Identify all rented equipment
- Give instructions

Additional Notes:

Orders

- Must be signed/dated by physician
- Faxed, photocopied, electronic, or pen & ink orders are acceptable for claim submission
- Must be kept on file by supplier
- Signature stamps are acceptable on orders

Additional Notes:

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- Must clearly state the start date
- Must include the length of need for rented equipment or when specified by policy
- Must be sufficiently detailed including:
 - All options or additional features
 - Brand name/model number OR narrative description
- The ICD-9-CM diagnosis code or narrative description can be on the order

Additional Notes:

- Supplies on a periodic basis:
 - Quantity used
 - Frequency of change
 - Duration of need
- “PRN” or “as needed” utilization estimates for supply replacement, use, or consumption are not acceptable

Additional Notes:

- If the supply is a drug:
 - Define the name of the drug
 - Concentration
 - Dosage
 - Frequency of administration
 - Duration of infusion (if applicable)

Additional Notes:

- A new order is required for the following situations:
 - Changes in the order for the accessory, supply, drug, etc.
 - On a regular basis, if specified in the documentation section of a particular medical policy
 - When an item is replaced
 - When there is a change in the supplier
- For items that require a CMN, and for accessories, supplies, and drugs related to an item requiring a CMN, the CMN may serve as the written order if the narrative description in Section C is sufficiently detailed
 - This applies to both hard copy and electronic CMNs

- A written order prior to delivery is required for:
 - Support Surfaces
 - Seat Lift Mechanisms
 - Transcutaneous Electrical Nerve Stimulators (TENS) Units
 - Power Mobility Devices (PMDs)
- If a supplier does not have a faxed, photocopied, electronic, or pen & ink signed order in their records before claim submission to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied as not reasonable and necessary
- If the item is one that requires a written order prior to delivery, the claim will be denied as not meeting the benefit category
- EY modifier should be appended

Additional Notes:

Certificate of Medical Necessity (CMN)

- Items which require a CMN:
 - Hospital Beds
 - Support Surfaces (Group 3 only)
 - Pneumatic Compression Devices
 - Osteogenesis Stimulators
 - TENS Units
 - Seat Lift Mechanisms
 - Infusion Pumps
 - Parenteral and Enteral Nutrition
 - Oxygen and Oxygen Equipment
- Link to CMN online
- DMERC Form Number
 - Top Right Corner
- CMS Form Number
 - Bottom Left Corner
- Instructions for completion on back

Additional Notes:

ABCDs of CMNs

- Section A - Supplier Completion
 - Certification Type/Date
Initial, Revised, or Recertification
 - Patient Information
 - Permanent legal address
 - HICN as it appears on Medicare card
 - Supplier Information
National Supplier Clearinghouse (NSC) number must include all ten (10) digits
 - Place of Service
Complete list - Online Supplier Manual
 - Facility Name (if applicable)
 - Healthcare Common Procedure Coding System (HCPCS) Codes
List only HCPCS codes that require a CMN
 - Patient Date of Birth (DOB), Height, Weight, Sex
 - Physician Information
Must include Unique Physician Identification Number (UPIN)

Additional Notes:

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 01.02A

HOSPITAL BEDS		
SECTION A		
Certification Type/Date:		INITIAL ___/___/___ REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(____)____-____ HICN _____		(____)____-____ NSC# _____
PLACE OF SERVICE _____	HCPCS CODE	PT DOB ___/___/___; Sex ___ (M/F); HT. ___ (in.); WT. ___ (lbs.)
NAME and ADDRESS of FACILITY if applicable (See reverse)	_____ _____ _____	PHYSICIAN NAME, ADDRESS (Printed or Typed)
		PHYSICIAN'S UPIN: _____
		PHYSICIAN'S TELEPHONE #: (____)____-____

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SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE: Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the physician's name and complete mailing address.

UPIN: Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

- Section B - Non-Supplier Completion:
 - A physician, physician's employee, or clinician may complete this section
 - Estimated length of need
 - Diagnosis codes
 - ICD-9 Codes - Not narrative description
 - Question section
All applicable questions must be answered
 - If person completing Section B is not the physician, provide the following:
 - Name
 - Title
 - Employer

SECTION B		Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.
EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 1, AND 3-7 FOR HOSPITAL BEDS (Circle Y for Yes, N for No, or D for Does Not Apply)	
	QUESTION 2 RESERVED FOR OTHER OR FUTURE USE.	
Y N D	1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?	
Y N D	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?	
Y N D	4. Does the patient require the head of the bed to be elevated <u>more than 30 degrees</u> most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?	
Y N D	5. Does the patient require traction which can only be attached to a hospital bed?	
Y N D	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?	
Y N D	7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):		
NAME: _____ TITLE: _____ EMPLOYER: _____		

Additional Notes:

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- SECTION B:** (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)
- EST. LENGTH OF NEED:** Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
- DIAGNOSIS CODES:** In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
- QUESTION SECTION:** This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
- NAME OF PERSON ANSWERING SECTION B QUESTIONS:** If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

- Section C - Supplier Completion
 - Must be completed prior to sending to physician
 - Narrative Description
 - Items listed in Section A and related supplies
 - Description of each item billed on a separate claim line
 - HCPCS codes are not required
 - Supplier's Charge For:
 - Each item listed
 - Purchased items - full charge
 - Rental items - "per month" or "/month"
 - Items replaced on a regular basis
 - Time span the items will be required

Additional Notes:

SECTION C	Narrative Description Of Equipment And Cost
<p>(1) <u>Narrative</u> description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option. (See Instructions On Back)</p>	

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SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

- Section D - Physician Only
 - Physician Attestation
Must be the physician listed in Section A
 - Physician Signature
Stamped signatures are not acceptable
 - Date of Physician Signature
Date stamps are not acceptable

Additional Notes:

SECTION D	Physician Attestation and Signature/Date
I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.	
PHYSICIAN'S SIGNATURE _____	DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

CMS-841 (04/06)

Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders and CMNs

- May give the dispensing order and sign the written order for the following situations:
 - Treating the beneficiary for the condition for which the item is needed;
 - Practicing independently of a physician;
 - Billing Medicare for other covered services using their own provider number; and
 - Permitted to do all of the above in the state in which the services are rendered
- May complete Section B and sign Section D of a CMN if they meet all the above criteria

Physician Assistant Rules Concerning Orders and CMNs

- May provide the dispensing order and write and sign the written order if they satisfy all of the following:
 - Meet the definition of the physician assistant found in the Social Security Act and the Medicare Carriers Manual;
 - Treating the beneficiary for the condition for which the item is needed;
 - Practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy;
 - Have their own UPIN; and
 - Permitted to perform services in accordance with state law
- May complete Section B and sign Section D of a CMN if they meet all the above criteria

Additional Notes:

CMN Cover Letter - Do

- Keep copy of cover letter in file
- Identify the supplier and beneficiary
- List procedure codes and describe items ordered
- Supply administrative information which does not relate to patient's medical condition
- Duplicate physician's verbal order
- Include direct quotes from medical policy or furnish entire policy
- Explain which sections physician must complete
- Instruct physician which questions must be answered
- Give address for return of form
- Send copies of pertinent reports

CMN Cover Letter - Don't

- Influence or instruct physician regarding what is medically necessary
- Suggest appropriate answers to questions
- Change the physician's description of the patient's condition or diagnosis

Additional Notes:

Additional DMERC Forms

Statement of Certifying Physician for Therapeutic Shoes

Patient Name: _____

HIC #: _____

I certify that all of the following statements are true:

1. This patient has diabetes mellitus.
2. This patient has one or more of the following conditions. (Circle all that apply):
 - a) History of partial or complete amputation of the foot
 - b) History of previous foot ulceration
 - c) History of pre-ulcerative callus
 - d) Peripheral neuropathy with evidence of callus formation
 - e) Foot deformity
 - f) Poor circulation
3. I am treating this patient under a comprehensive plan of care for his/her diabetes.
4. This patient needs special shoes (depth or custom-molded shoes) because of his/her diabetes.

Physician signature: _____

Date Signed: _____

Physician name (printed - **MUST BE AN M.D. OR D.O.**):

Physician address:

Physician UPIN: _____

Additional Notes:

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Statement of Ordering Physician Group 1 Support Surfaces

Patient name: _____

HIC #: _____

Cost information (to be completed by the supplier):

Supplier's charge _____

Medicare fee schedule allowance _____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Indicate which of the following conditions describe the patient. Circle all that apply:

- 1) Completely immobile—i.e. patient cannot make changes in body position without assistance.
- 2) Limited mobility—i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.
- 3) Any pressure ulcer on the trunk or pelvis.
- 4) Impaired nutritional status.
- 5) Fecal or urinary incontinence.
- 6) Altered sensory perception.
- 7) Compromised circulatory status.

Estimated length of need (# of months): _____ (99=lifetime)

If none of the above apply, attach a separate sheet documenting medical necessity for the item ordered.

Physician name (printed or typed): _____

Physician signature: _____

Physician UPIN: _____

Statement of Ordering Physician Group 2 Support Surfaces

Patient name: _____

HIC #: _____

Cost information (to be completed by the supplier):

Supplier's charge _____

Medicare fee schedule allowance _____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Circle **Y** for Yes, **N** for No, **D** for Does not apply, unless otherwise noted.

- Y N D 1) Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?
- Y N D 2) Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a nonpowered pressure reducing overlay or mattress?
- 1 2 3 3) Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same
3) Worsened?
- Y N D 4) Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?
- Y N D 5) Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give date of surgery:
- Y N D 6) Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

Estimated length of need (# of months): _____ (99=lifetime): _____

Physician name (Printed or typed): _____

Physician signature: _____

Physician UPIN: _____

Date signed: _____

Additional Notes:

**MEDICARE BENEFICIARY STATEMENT:
Evaluation of Respiratory Assist Device**

Beneficiary Name: _____ Beneficiary Birth Date: __ / __ / __

Beneficiary Telephone Number: (____) - ____ - _____

The Supplier May Not Answer Any Of The Following Questions.

1. Are you (the Medicare beneficiary) now using a machine that helps you take your breaths while you are asleep (separate from a machine that may be giving you oxygen or medicine)?

YES NO

2. How many hours a day do you usually use this machine?

_____ HOURS

3. How many months have you been using this machine?

_____ MONTHS

4. Will you keep using this treatment in the future?

YES NO

5. Did you (the Medicare Beneficiary) complete answers #1 – 5?

YES NO

If you did not answer these questions, who did and what is their relationship to you (for example, wife, husband, supplier of machine, etc.)?

Name (Print): _____ Relationship: _____

Beneficiary signature

Date of signature

Additional Documentation

- Extra Documentation
 - Paper Claims
 - Item 19
 - Electronic Claims
 - NTE 2300 (ANSI)
 - NTE 2400 (ANSI)
- Most pertinent information that is needed to process the claim in NTE 2300 or NTE 2400
- Abbreviations should be used to maximize space available
- The abbreviations list is located at:
 - www.umd.nycpic.com/edidocfiles.html#Abbrev
- Use a cover sheet
- Fax at least 48 hours prior to claim submission
- Documentation may also be mailed
- Indicate in the narrative field
 - “Added documentation faxed” & the date faxed
- Additional Documentation Fax Number:
 - 570-255-9402
- Reminder: CMNs are not considered additional documentation
- CMNs are a part of the claim and have to be submitted electronically with electronic claims

Additional Notes:

Extra Documentation Region A DMERC

All information below **must** be completed:

Contact Name: _____
Company Name: _____
Supplier #: _____
Company Phone #: _____
Beneficiary Name: _____
Health Insurance Claim (HIC) #: _____
Procedure Code(s): _____
Date of Service: _____
Number of Services: _____

What is documentation for? Check one of the following:

Documentation for new claim: _____
Individual Consideration: _____
Over Utilization: _____

Documentation is for (check one): Electronic Claim ____ Paper Claim ____

Please use this cover sheet for any documentation sent to our office.
This will help in the timely processing of your claim.

Mail To:
HealthNow New York Inc.
DMERC A
PO Box 6800
Wilkes-Barre, PA 18773-6800

Electronic Submitters
may fax 48 **business** hours
[two (2) business days] before
claims are transmitted
Fax #: 570-255-9402

Proof of Delivery

Documentation Requirements

- Proof of delivery documentation required
- Documentation maintained for seven years
- Verification of beneficiary receipt of DMEPOS
- Supplier standard #12
- Proof of delivery documentation must be made available to the DMERC upon request
- Penalties imposed for suppliers that do not retain proof of delivery
- Suppliers may deliver to beneficiary or their designee
 - Designee - Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary
- Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary
- Example of proof of delivery is a signed delivery slip
- Recommended Components of a Delivery Slip:
 - Patient's name
 - Quantity delivered
 - Detailed description of the item being delivered
 - Brand name
 - Serial number
- The date of signature on the delivery slip must be the date that the DMEPOS item was received
- The relationship of the designee should be noted on the delivery slip

Shipping Service and Mail Order

- Examples of proof of delivery:
 - Delivery service's tracking slip **and** the supplier's own shipping invoice, **or**
 - A return postage-paid delivery invoice
- Suppliers shall use the shipping date as the date of service on the claim
- Exceptions:
 - Supplier may deliver DMEPOS item to a beneficiary two (2) days prior to discharge for training.
 - Supplier may not bill for drugs or other DMEPOS items used by beneficiary prior to discharge from the hospital or Medicare Part A nursing facility stay.

Proof of Delivery for Refills

- Supplier must contact the beneficiary prior to dispensing a refill
 - Contact can take place no more than seven days prior to the delivery/shipping date
- Refills should not be delivered more than five days prior to the end of the usage period
- For delivery to nursing home residents, the DMERC may request documentation of proof of delivery or usage by the beneficiary

Additional Notes:

Signature Requirements

Beneficiary Signature Requirements

- Item 12 on the CMS-1500 form for beneficiary signature or statement: “Signature on file”
- Supplier may obtain an authorization from the beneficiary/representative which allows submission of claims over an extended period of time or lifetime
- If the supplier obtains a release form they agree to:
 - Complete and submit claims on behalf of the beneficiary
 - Notify Medicare beneficiary that the claim will be submitted on their behalf
 - Provide such files upon request to the DMERC

Additional Notes:

Provider Signature Requirements

- Paper claim
 - Actual signature
 - Preprinted supplier name
- Electronic claim
 - Signature statement on file

Additional Notes:

Modifiers

- **A1-A9** - For number of wounds from one (1) through nine (9)
- **AU** - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
- **AV** - Item purchased in conjunction with a prosthetic device, prosthetic, or orthotic
- **AW** - Item furnished in conjunction with a surgical dressing
- **AX** - Supplies and equipment furnished in conjunction with dialysis services
- **BA** - Item furnished in conjunction with parenteral/enteral nutrition (PEN) services
- **BO** - Orally administered nutrition
- **BP** - The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
- **BR** - The beneficiary has been informed of the purchase and rental option and has elected to rent the item
- **BU** - The beneficiary has been informed of the purchase and rental options and after 30 days, the beneficiary has not informed the supplier of their decision
- **EY** - No physician or other licensed health care provider order for this item or service
- **GA** - Waiver of liability statement on file
- **GK** - Actual item/service ordered by physician, item associated with GA or GZ modifier
- **GL** - Medically unnecessary upgrade provided instead of standard item, no charge, no advance beneficiary notice (ABN)
- **GY** - Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- **GZ** - Item or service expected to be denied as not reasonable and necessary
- **K0-K4** - Lower extremity prosthesis functional level 0 through functional level 4
- **KB** - Beneficiary requested upgrade for ABN more than four (4) modifiers identified on claim
- **KC** - Replacement of special power wheelchair interface
- **KF** - Item designated by FDA as Class III device
- **KH** - DMEPOS item, initial claim, purchase of first month rental
- **KI** - DMEPOS item, second or third month rental
- **KJ** - DMEPOS item, parenteral/enteral nutrition (PEN) pump or capped rental, months four to fifteen
- **KX** - Specific required documentation on file
- **LT** - Left side (used to identify procedures performed on the left side of the body)
- **MS** - Six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturer or supplier warranty
- **NU** - New equipment
- **RR** - Rental (use the RR modifier when DME is to be rented)
- **RT** - Right side (used to identify procedures performed on the right side of the body)

Additional Notes:

Advance Beneficiary Notice (ABN)

- Notifies the beneficiary in writing:
 - Medicare will probably deny payment for that service or item
 - Reason the physician, provider, or supplier expects Medicare to deny payment
 - They will be personally and fully responsible for payment if Medicare denies payment
- If the physician or supplier expects payment for the items or services to be denied by Medicare:
 - He/she must advise the beneficiary before the items or services are furnished that in his/her opinion the beneficiary will be personally and fully responsible for payment
 - Notification must be on the approved CMS form, CMS-R-131
 - ***www.cms.hhs.gov/cmsforms/downloads/cmsr-131-g.pdf***

Additional Notes:

Patient's Name:

Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ _____**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

- ABN is designed for use only with Medicare beneficiaries
- ABN is used to inform a Medicare beneficiary, before he or she receives specified items or services that otherwise might be paid for, that Medicare probably will not pay for them on that particular occasion
- ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out-of-pocket or through other insurance
- The ABN must:
 - Clearly identify the particular item or service
 - State that the physician or supplier believes Medicare is likely to deny payment
 - Give the physician's or supplier's reason(s) for their belief that Medicare is likely to deny payment for the item or service
- Generic ABN:
 - Not acceptable evidence of Advance Beneficiary Notice
 - State denial is possible
 - Statement indicating if Medicare claim is denied, patient will be held responsible
 - Generic ABNs are defective notices and will not protect the physician or supplier from liability
- Delivery of an ABN:
 - Should be hand delivered
 - Must be delivered with an original and at least one copy
 - Telephone notice is not sufficient evidence or proper notification
 - Delivery of a notice is not considered properly done if the beneficiary or beneficiary's representative cannot comprehend the notice
- An ABN can be given to a Medicare beneficiary or authorized representative (person acting on beneficiary's behalf) when the beneficiary is temporarily or permanently unable to act for himself or herself
- Delivery of an ABN occurs when the beneficiary or authorized representative both have received the notice and can comprehend its contents

Additional Notes:

Definitions of ABN Modifiers

- **GA** - Waiver of liability (expected to be denied as not reasonable and necessary, ABN on file)
- **GZ** - Item or service not reasonable and necessary (expected to be denied as not reasonable and necessary, no ABN on file)
- **GK** - Actual item/service ordered by physician, item associated with GA or GZ modifier
- **KB** - Beneficiary requested upgrade for ABN, more than four (4) modifiers identified on claim
 - Paper claims - Append the **KB** modifier to the line and place all other modifiers in Item 19 indicating the line to which they apply

- Electronic claims - Append the **KB** modifier to the line and place the ABN modifiers in the NTE 2300 record of the ANSI format for the whole claim or the NTE 2400 record of the ANSI format, per claim line

THESE REQUIREMENTS RELATE TO THE ABN USED FOR BENEFICIARY-REQUESTED UPGRADES ONLY.

Additional Notes:

Beneficiary Requested Upgrades

Beneficiary Requested Upgrade with an ABN on File

- Bill two (2) line items per claim
- Line 1 HCPCS for upgraded item plus **GA** modifier
- Line 2 HCPCS for doctor-ordered item plus **GK** modifier
- Note: Examples will be shown on the slide show only.

Additional Notes:

Beneficiary Requested Upgrade without an ABN on File

- Bill two (2) line items per claim
- Line 1 HCPCS for upgraded item plus **GZ** modifier
- Line 2 HCPCS for doctor-ordered item plus **GK** modifier
- Note: Examples will be shown on the slide show only

Additional Notes:

Supplier Invoked Free Upgrades

Filing a Claim without an ABN on File

- Bill one line item per claim
- Line 1 HCPCS for doctor-ordered item plus **GL** modifier

- Note: Examples will be shown on the slide show only

Additional Notes:

Program Safeguard Contractor (PSC)

PSC Affiliated with DMERC A

- TriCenturion
 - Medical Policies
 - HCPCS
 - Benefit Integrity
- www.tricenturion.com

Additional Notes:

Comprehensive Error Rate Testing (CERT)

What is CERT?

- CERT is a program that ensures that Medicare claims are paid correctly and accurately by consistently reducing the number of errors made in claims adjudication
- The Centers for Medicare & Medicaid Services (CMS) use the error rate findings to determine underlying reasons for claim errors and to develop appropriate action plans to improve compliance in payment, claims processing, and provider billing practices
- When a claim has been selected for review by CERT, the provider will receive a letter from the CERT Documentation Contractor requesting the documentation for the services under review

Additional Notes:

Who are the CERT Contractors?

The CERT Documentation Contractor (CDC)

- Responsible for requesting and receiving the medical record documentation from providers

CERT Review Contractor (CRC)

- Responsible for reviewing the selected claims and associated medical record documentation

How should providers respond to a CERT request?

- Suppliers will be contacted via telephone by the CDC prior to the initial request letter being sent
- Next, the provider will receive a letter from the CDC requesting the documentation for the services under review
- The preferred method for receipt of medical records or documentation is via fax:
 - 240-568-6222

When should providers respond to a CERT request?

- Suppliers should respond immediately!
- Must respond within 90 days from the date of the initial request letter
- CERT contractor will send repeat letters and may contact you by telephone. Example CERT Letter

Additional Notes:

Example CERT Letter

- Please note: An example CERT letter will be shown on the slide only

What will happen if providers choose not to respond?

- Non-responders
 - May be contacted by TriCenturion (PSC) via telephone or fax
 - The claim will be considered an error against the Medicare contractor and the supplier
 - An overpayment will be taken for the claim

November 2005 Improper Payment Report

- Provider Compliance Error Rate
 - 12.7% (Including No Documentation Claims)
 - 10.1% (Excluding No Documentation Claims)

Top Five Policy Groups

Glucose Monitors
Lower Limb Prostheses
Surgical Dressings
Ostomy Supplies
Nebulizers

Questions or Comments

- Contact the CERT Operations Center:
 - 301-957-2380

Additional Notes:

CERT Web Resources

- CMS CERT Web site
 - www.cms.hhs.gov/cert
- DMERC A CERT Web site
 - www.umd.nycpic.com/dmerc_cert.html#links
- CERT Documentation Contractor (CDC) Web site
 - www.certprovider.org/

Resources

- Caller Information Network
 - Provider: 866-419-9458
 - Beneficiary: 1-800-MEDICARE
 - 1-800-633-4227
- Program Education & Training
 - 570-255-9666
- www.umd.nycpic.com

DMERC A ListServes

- What is a ListServe?
 - Email account that provides an opportunity for subscribers to receive reminders and announcements
- Benefits of a ListServe
 - Know important and time-sensitive Medicare program information and all other important or urgent announcements

- Learn about upcoming educational opportunities and training events
- Know when our quarterly bulletins become available
- www.umd.nycpic.com/dmlistserve.html

Additional ListServes

- National Heritage Insurance Company (NHIC) - Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Region A
 - www.medicarenhic.com/dme/index.shtml
- TriCenturion
 - www.tricenturion.com
- Centers for Medicare and Medicaid Services (CMS)
 - www.cms.hhs.gov/apps/maillinglists/

Additional Notes:

Questions and Answers

Thank You