DME Accreditation Requirement Apparently To Be Discontinued for ODs

Hot from the AOA:
The AOA Washington Office has just learned that CMS officials have notified the National Supplier Clearinghouse (NSC) that “new” durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier applications from physicians, including ODs, will not require accreditation. This will provide immediate relief for optometrists across the country who have been barred from enrollment or re-enrollment as DMEPOS suppliers without going through the accreditation process, including payment of a substantial accreditation fee.

This reversal by CMS is a result of a months-long lobbying effort by the AOA and other provider groups aimed at winning needed changes in the misguided DMEPOS accreditation requirement announced earlier this year. In fact, during the most recent meeting with CMS officials on this issue August 28th, Kelly Hipp and Rodney Peele of the AOA Washington Office team again detailed the harmful impact on ODs and patients of extending the accreditation requirement to post-cataract eyewear.

In addition to making the case directly to CMS, the AOA was successful in mobilizing pro-optometry leaders in Congress to support inclusion of a DMEPOS accreditation regulatory relief provision in legislation to avert massive Medicare physician payment cuts. Although the AOA-backed Medicare Improvements for Providers and Patients Act of 2008 (MIPPA) became law on July 15th when Congress overrode the President’s veto, CMS had been resisting full implementation of the DMEPOS provision until now.

(Continued on page 5)

Inside this issue:
The CMS Online Manual System offers day-to-day operating instructions, policies, and procedures.  
The 2009 ICD-9-CM will be required for dates of service on and after October 1, 2008. 
The WPS Medicare Listserv delivers the latest in Medicare news, right to your email account. 
For electronic filers, WPS explains into which electronic data loops you must put CMS-1500 data items. 
After October 1, 2008, CMS applications must be submitted on the 2008 versions of the CMS-855 forms. 
Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. 
A coding lesson on Refractive Lenses is currently available on a DME Coverage and Specialty course. 
Unpaid claim information is available from Noridian via their IVR; call 1-877-320-0390.
Common Electronic Data Interchange (CEDI) recently updated the Express Plus software manual. 
If any DME claim line contains an EY modifier, all other claim lines on that claim must contain it as well. 
Medicare Secondary Payer (MSP) claims should also be filed electronically. Details explained. 
DME Electronic Submitters should review CEDI reports. 
Complete claim item 32 on all claims that do NOT have a place of service = home (i.e., not POS= 12). 
AOA has an E-prescribing Readiness Assessment now available on line. 
AOA has a service for evaluating participation in insurance plans. 
Stamped signatures are not acceptable on any medical record. 
Bandage CL coding explained. 
How to prepare your office for a Record Review by a 3rd party.
The U.S. Centers for Medicare & Medicaid Services (CMS) Online Manual System is used by CMS program components, providers, contractors, and state agencies to administer CMS programs. It offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives. These instructions are located in the CMS Online Manual System at [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals) and are a replica of the official record copy. The IOM manual index can be found at [http://www.cms.hhs.gov/manuals/IOM/list.asp](http://www.cms.hhs.gov/manuals/IOM/list.asp).

Of particular interest to the provider is Publication 100-04, the [Medicare Claims Processing Manual](http://www.cms.hhs.gov/manuals/IOM/list.asp), which gives instructions on billing and the correct method to file claims.

[Dr. Quack note: if the above hyperlink does not work on your computer (the URL may contain too many characters), use the hyperlink to the manual index in the previous paragraph, and then click on Medicare Claims Processing Manual.]


<table>
<thead>
<tr>
<th>Publication number</th>
<th>Functional Area Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUBLICATION 100</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>PUBLICATION 100-01</td>
<td>MEDICARE GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT</td>
</tr>
<tr>
<td>PUBLICATION 100-02</td>
<td>MEDICARE BENEFIT POLICY</td>
</tr>
<tr>
<td>PUBLICATION 100-03</td>
<td>MEDICARE NATIONAL COVERAGE DETERMINATIONS</td>
</tr>
<tr>
<td>PUBLICATION 100-04</td>
<td>MEDICARE CLAIMS PROCESSING</td>
</tr>
<tr>
<td>PUBLICATION 100-05</td>
<td>MEDICARE SECONDARY PAYER</td>
</tr>
<tr>
<td>PUBLICATION 100-06</td>
<td>MEDICARE FINANCIAL MANAGEMENT</td>
</tr>
<tr>
<td>PUBLICATION 100-07</td>
<td>MEDICARE STATE OPERATIONS</td>
</tr>
<tr>
<td>PUBLICATION 100-08</td>
<td>MEDICARE PROGRAM INTEGRITY</td>
</tr>
<tr>
<td>PUBLICATION 100-09</td>
<td>MEDICARE CONTRACTOR BENEFICIARY AND PROVIDER COMMUNICATIONS</td>
</tr>
<tr>
<td>PUBLICATION 100-10</td>
<td>MEDICARE QUALITY IMPROVEMENT ORGANIZATION</td>
</tr>
<tr>
<td>PUBLICATION 100-11</td>
<td>MEDICAID STATE AGENCIES NOTIFICATION</td>
</tr>
<tr>
<td>PUBLICATION 100-12</td>
<td>STATE MEDICAID</td>
</tr>
<tr>
<td>PUBLICATION 100-13</td>
<td>MEDICAID STATE CHILDREN’S HEALTH INSURANCE PROGRAM</td>
</tr>
<tr>
<td>PUBLICATION 100-14</td>
<td>MEDICARE END-STAGE RENAL DISEASE NETWORK ORGANIZATION</td>
</tr>
<tr>
<td>PUBLICATION 100-15</td>
<td>MEDICARE STATE BUY-IN</td>
</tr>
<tr>
<td>PUBLICATION 100-16</td>
<td>MEDICARE MANAGED CARE</td>
</tr>
<tr>
<td>PUBLICATION 100-17</td>
<td>MEDICARE BUSINESS PARTNERS SYSTEMS SECURITY</td>
</tr>
<tr>
<td>PUBLICATION 100-18</td>
<td>RESERVED*</td>
</tr>
<tr>
<td>PUBLICATION 100-19</td>
<td>DEMONSTRATION</td>
</tr>
<tr>
<td>PUBLICATION 100-20</td>
<td>ONE-TIME NOTIFICATION</td>
</tr>
</tbody>
</table>
The New 2009 ICD-9-CM Required October 1st.

CMS reminds all providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2008. You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Website at http://www.cdc.gov/nchs/icd9.htm in June of each year.

For more information, read the entire article online at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6107.pdf

Quack note: regarding diagnoses possibly used by ODs, there are ICD-9-CM changes related to headaches (especially migraine), retinopathy of prematurity, and secondary diabetes.

CMS-855 MEDICARE ENROLLMENT APPLICATIONS - 2008 REVISIONS

The Centers for Medicare & Medicaid Services (CMS) revised the CMS-855 Medicare enrollment applications in February 2008. The current versions of the applications are available on the CMS Provider Enrollment Website at http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp. Applications received by CMS on and after October 1, 2008 must be submitted on the 2008 versions of the forms. The 2006 versions of the forms will no longer be accepted effective October 1, 2008 and will be returned to the applicant.

CMS-1500 to Electronic Claims Crosswalk

For those who file electronically, there is a WPS source that explains where to insert the CMS-1500 data items into which electronic claim data loop. This is referred to as the CMS-1500 Electronic Claim Crosswalk, and can be found at http://www.wpsmedicare.com/mac/business/cms1500_xwalk.pdf

HHS Takes New Steps (read $$$) to Accelerate Electronic Prescribing

Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be available beginning in 2009 for physicians who meet the requirements of the program. The initiative is part of the Administration’s broader efforts to accelerate the adoption of health IT and the establishment of a health care system based on value.

Beginning in 2009, and during the next four years, Medicare will provide incentive payments to eligible professionals who are successful electronic prescribers. Eligible professionals will receive a 2 percent incentive payment in 2009 and 2010; a 1 percent incentive payment in 2011 and 2012; and a one half percent incentive payment in 2013. Shortly thereafter, eligible professionals who are not successful electronic prescribers will receive a reduction in payment. Eligible professionals may be exempted from the reduction in payment, on a case-by-case basis if it is determined that compliance with requirement for being a successful prescriber would result in significant hardship.

To read more, see the entire HHS Fact Sheet at http://www.hhs.gov/news/facts/eprescribing.html.

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To read more, see the entire HHS Fact Sheet at http://www.hhs.gov/news/facts/eprescribing.html.
A new lesson, entitled *Refractive Lenses*, is now available on the Online Learning Center (OLC) under the DME Coverage and Specialty course.

The OLC is a self-paced learning environment that allows suppliers to take pre and post-assessments, complete lessons, view resources and participate in surveys. Suppliers can take advantage of this self-service technology 24 hours a day/7 days a week and can participate in a course as often as they would like.

**Refractive Lenses**

Are you having difficulty getting your claims paid by the DME MAC? Are you unsure of how to complete the claim form for deluxe frames or lenses? Are you perplexed by the coverage requirements?

If your answer to any of these questions was yes, or you just need a refresher course, then this is the lesson for you. Refractive Lenses if the first lesson offered within our DME Coverage and Specialty course. This self-paced lesson includes information on:

- Claim submission
- Coverage
- Coding for lenses
- Documentation

2. The next screen will be course categories. Click on Durable Medical Equipment.
3. On the next screen, at the bottom left, click on DME Coverage and Specialties.
4. Take the course on Refractive Lenses (which is broken into parts).

To access outstanding claim information (aka “payment floor” information) from the Noridian Interactive Voice Response (IVR) Main Menu:

2. Use the voice activation option by saying “payment floor” or press 7 on the phone keypad.
3. In order to access payment floor information, you will need to provide your:
   - NPI
   - PTAN (your old legacy number)
4. The IVR will provide the following payment floor information:
   - Number of pending claims
   - Total dollar amount of pending claims
   - Number of claims on the payment floor
   - Total dollar amount on the payment floor
5. After payment floor information is provided, the IVR will explain the next options, which you can either speak or key:
   - Repeat That (Press 1)
   - Change PTAN (Press 2)
   - Change NPI (Press 3)
   - Main Menu (Press 8)

Benefits of contacting the IVR for payment floor inquiries are:

- No hold time
- The ability to check multiple NPI and PTAN numbers
- Longer hours for the IVR as compared to the Contact Center.

The IVR is available from 6 am - 6 pm CT, whereas the contact center hours are 8 am - 5:30 pm CT. An updated IVR User Guide has been added to the Contact section of the Noridian web site.

Noridian DME: Information for Express Plus Software Users


National Government Services, Common Electronic Data Interchange (CEDI) is announcing the availability of the NCPDP Error Code Manual on the CEDI Web site. The NCPDP Error Code Manual provides a listing of all NCPDP edit numbers, descriptions, element/segment ID references, edit explanations and report examples. To access this manual use the following link
http://www.ngscedi.com/outreach_materials/outreachindex.htm


It is essential that all trading partners/electronic submitters download and review all front end reports returned by CEDI. Trading partners/electronic submitters should use the edit error manuals available to resolve rejections prior to contacting the CEDI Help Desk.

DME Vision Items Requiring EY Modifier Must be Filed Separately

When submitting a claim to Medicare for items which
♦ Would be covered if ordered by a physician,
♦ But in this case the items were a patient preference item, and thus dispensed without a physician order,
then the supplier must append the EY modifier to the HCPCS code. This includes items that may, or may not be, patient preference items such as
♦ Anti-reflective coating (V2750),
♦ Polycarbonate or Trivex \textsuperscript{tm} lenses (V2784),
♦ Tints (V2744, V2745) or
♦ Oversized lenses (V2780),
as described in the Refractive Lenses Local Coverage Determination.

Suppliers must report their own name and NPI number as the ordering/referring physician on claims submitted without a physician order. The EY modifier must be on all line items for that claim. The claim cannot contain a mixture of order and non-ordered items. Physician-ordered items must be billed separately.

Claims submitted with a mixture of ordered and non-ordered items will be denied as unprocessable. The remittance advice message reported on these denied claims is CO-4: “The procedure code is inconsistent with the modifier used or a required modifier is missing”.

DME Accreditation Requirement Apparently To Be Discontinued

(Continued from page 1)

Since March 1, CMS had been requiring all “new” suppliers to get accredited before they could enroll and obtain an NSC number. AOA has repeatedly objected to this requirement, particularly since “new” suppliers included some physicians who were merely changing practice locations or adding new locations. The accreditation deadline for DMEPOS suppliers who are already enrolled with Medicare is September 30, 2009.

CMS will host a Special Open Door Forum on Wednesday, September 3, from 2 to 3:30 EDT (1-2:30 CDT; 12:00-1:30 MDT) to announce its plans for DMEPOS accreditation for physicians in light of MIPPA. The Special Open Door Forum is a national conference call that is open to the public. To participate in the Special Open Door Forum, AOA members may call 1-800-837-1935 and reference Conference ID 61231070.
Noridian DME: Medicare Secondary Payer (MSP) Electronic Claim Submission

The Administrative Simplification and Compliance Act (ASCA) requires Medicare providers to submit all initial Medicare claims for reimbursement electronically, unless granted an ASCA waiver. This includes Medicare Secondary Payer (MSP) claims.

An MSP claim may be submitted to Medicare for payment only after the primary insurer has processed the claim and provided an Explanation of Benefits (EOB) or payment notice. It is the supplier’s responsibility to determine if Medicare is the primary or secondary payer for each beneficiary. Please see the Medicare Secondary Payer Fact Sheet located at www.cms.hhs.gov/NHINProducts/downloads/MSP_Fact_Sheet.pdf for information on determining whether Medicare is primary or secondary.

For supplier convenience, NAS provides an example of an intake form at www.noridianmedicalcare.com/dme/forms/docs/intake_form.pdf. This form contains questions that may help suppliers obtain information relevant to the beneficiary’s insurance coverage when the beneficiary begins receiving DME.

**EOB Formats**

There is no standard format for how insurance companies report payment information on their EOBs. Insurers may report information in a manner that requires the supplier to perform calculations to find the correct amounts to submit on the MSP claim. Suppliers are encouraged to contact the primary insurer with any questions about how to interpret the EOB.

Software vendors may also have different ways of allowing for entry of MSP information in electronic claim submission software or billing software, even though the claims must be submitted using the HIPAA mandated ANSI specifications. Suppliers looking for software that supports MSP electronic claims submission are encouraged to visit the National Government Services Common Electronic Data Interchange (CEDI) website at www.ngscedi.com for more information.

Because of the lack of these EOB reporting standards, the information provided in this article will be general rather than specific to one EOB format or one claims billing software format.

**Submitting MSP Claims**

Once a claim has been paid by the primary insurer and an EOB is sent to the supplier, the MSP claim can be submitted to Medicare. There are key pieces of information contained on the EOB that must be entered on an MSP electronic claim. MSP payments cannot be determined without this information:

- **Allowed Amount**
- **Paid Amount**
- **Obligation to Accept Payment in Full Amount (OTAF)**

All software that supports MSP electronic claims submission will allow for this information to be entered and submitted to Medicare.

In addition, some claims submission software also contains fields for **Deductible** and **Co-Insurance** amounts. Please include those amounts when possible.

There is no need to provide a paper copy of the EOB when submitting an MSP claim electronically.

**Definitions:**

- **Allowed Amount**—maximum amount the primary insurer will pay for an item or service based on the insurer’s contract with the beneficiary.
- **Paid Amount**—actual amount paid by the insurer for the item or service, after co-insurance and deductibles are factored in.
- **OTAF Amount**—amount that you, the supplier, agreed to accept as payment in full for the item or service (the amount the primary payer paid plus the amount that is patient responsibility).
- **Deductible Amount**—amount the beneficiary must pay for health care before the insurer begins to make payments.
- **Co-Insurance Amount**—amount that is the beneficiary’s responsibility to pay for each item or service. This is usually a percentage of the allowed amount.

In most claims processing software products, the Allowed Amount, Paid Amount, and OTAF Amount are entered at the claim level. These amounts may also be entered at the line level and we encourage this when possible.

Suppliers should be aware that when only claim level information is provided, if any line on the claim denies, NAS must deny the entire claim.

Therefore, when there are multiple lines on a single claim, it is in the suppliers’ best interest to submit these amounts at the line level. This provides NAS enough information to process payments on the lines of the claim that were not denied and can provide the supplier with at least partial payment.

**MSP claims must balance at the claim level.**

Out-of-balance MSP claims will be denied or suspended, requiring additional time to process. Incorrect or incomplete MSP claims submissions may be denied or suspended, requiring additional time to process.

Other reminders for submitting MSP claims are:

- Medicare is primary over supplemental insurance, such as Medicaid and TriCare.
- MSP claims related to auto and liability and workers compensation are generally diagnosis driven.
- When Medicare is secondary, claims should be submitted first to the primary insurer and then to Medicare.

Medicare Advantage plans sold by private insurers are a type of managed care. Medicare may not coordinate benefits if the beneficiary has a managed care plan.

- If the billed amount is different than the primary allowed, indicate whether the beneficiary or the supplier is liable.
- EOBs may identify a “Submitted Amount.” This is the amount the supplier submitted on the original request for payment (the price of the item/service). The submitted amount should not be used as the allowed Amount, unless the amount in the EOB is different from the allowed amount.

(Continued on page 7)
two amounts are exactly equal.

- If the beneficiary’s benefits have been exhausted, there should be no amount listed in the primary allowed field.
- If the beneficiary is liable, there is no DTAF.

Using the correct forms speeds processing of requests: Use the MSP Inquiry and Refunds Form to request any MSP-related changes to payment (i.e., Medicare paid primary and should have paid secondary and vice versa).

Use the DME Inquiry/Redetermination form to request further review when a claim is denied for reasons other than MSP (i.e., insufficient documentation, medical necessity), even if there is a primary insurer.

When a claim is filed in a timely manner and meets all other filing requirements of the third-party payer (TPP), the amount of secondary benefits payable by Medicare is the lowest of three figures:

1. Actual charge by the provider (or the amount the provider is obligated to accept as payment in full if that is less than the charges) minus the amount paid by the third-party payer;
2. Amount Medicare would pay if services were not covered by a TPP;
3. Higher of the Medicare fee schedule or other amount that would be payable under Medicare (without regard to any Medicare deductible and/or coinsurance amounts) or the TPP’s allowable charge (without regard to any copayment imposed by the policy or plan) minus the amount actually paid by the TPP.

EXAMPLE 1: An individual received treatment from a physician who charged $175. The individual’s Part B deductible had been met. As a primary payer, an employer allowed $150 of the charge and paid 80 percent of this amount or $120. The fee schedule amount for this treatment is $125. The Medicare secondary payment is calculated as follows:

1. Actual charge by the physician minus the third party payment: $175 - $120 = $55.
2. Determine the Medicare payment in the usual manner: .80 x $125 = $100.
3. Employer plan’s allowable charge of $150 (which is higher than Medicare’s fee schedule amount of $125) minus the employer plan’s payment of $120 equals $30.

Pay $30 (lowest of amounts in steps 1, 2, or 3).

EXAMPLE 2: An individual received treatment from a physician who charged $50. The individual’s Part B deductible had been met. As a primary payer, an employer plan allowed a fee schedule payment of $20. The Medicare fee schedule amount for the treatment is $40. The Medicare secondary payment is calculated as follows:

1. Actual charge by the physician minus the third party payment: $50 - $20 = $30.
2. Determine the Medicare payment in the usual manner: .80 x $40 = $32.
3. Medicare’s fee schedule amount of $40 (which is higher than the employer plan’s allowable charge of $20) minus the employer plan’s payment of $20 equals $20.

Pay $20 (lowest of amounts in steps 1, 2, or 3).

EXAMPLE 3: An individual received treatment from a physician who charged $140. The individual’s unmet Part B deductible was $100. As a primary payer, an employer plan allows $120 and paid 80 percent of this amount or $96. The Medicare fee schedule amount for his treatment is $100. The Medicare secondary payment is calculated as follows:

1. Actual charge by the physician minus the third party payment: $140 - $96 = $44.
2. Determine the Medicare payment in the usual manner: $100 - $100 x .80 = $8.
3. Employer plan’s allowable charge of $120 (which is higher than Medicare’s fee schedule amount of $110) minus the employer plan’s payment of $96 equals $24.

Pay $8 (lowest of amounts in steps 1, 2, or 3).

The beneficiary’s Medicare deductible is credited with $100, the amount that would have been credited to the deductible based on the fee schedule amount of $100 if Medicare had been primary payer.

The beneficiary can be charged $5 (the $100 fee schedule amount minus the sum of the $96 primary payment plus the $3 Medicare payment).

EXAMPLE 4: An individual received treatment from a physician who charged $250. The individual had previously met $50 of the $100 Part B deductible for that year. As primary payer, an automobile insurer allowed the $250 charge in full. The insurer deducted $100 from the $250 physician charge to meet its own deductible and paid 80 percent of the remaining $150, or $120. The Medicare fee schedule amount for this treatment is $200. The Medicare secondary payment is calculated as follows:

1. Actual charge by the physician minus the third party payment: $250 - $120 = $130.
2. Determine the Medicare payment in the usual manner: $200 - $130 x .80 = $200.
3. TPP’s allowable charge of $250 (which is higher than Medicare’s fee schedule amount of $200) minus its payment of $120 equals $130.

Pay $120 (lowest of amounts in steps 1, 2, or 3).

The beneficiary’s Medicare deductible is credited with $50, the amount that would have been credited to the deductible based on the fee schedule amount of $200 payable if Medicare had been primary payer.

EXAMPLE 5: An individual received treatment from a physician who charged $360. The individual paid the physician $50 and the physician also filed a claim with a GHP. The individual’s unmet Medicare deductible was $100. The GHP’s allowable charge was $250 and, as a primary payer, it paid the physician $210. The claim showed the total charge and other amounts paid by the GHP and the individual. The Medicare fee schedule amount for the treatment is $300. The Medicare secondary payment is calculated as follows:

1. Actual charge by the physician minus the third party payment: $360 - $210 = $150.
2. Determine the Medicare payment in the usual manner: $300 - $150 x .80 = $210.
3. Medicare’s fee schedule amount of $300 (which is higher than the GHP’s allowable charge of $250) minus the GHP’s payment of $210 equals $90.

Pay $90 (lowest of amounts in steps 1, 2, or 3).

EXAMPLE 6: An individual received treatment from a physician who charged $75. The individual’s Part B deductible had been met. As a primary payer, an employer plan allows $160 but has a preferred physician arrangement under which the physician agrees to accept 50 percent of the plan’s allowable amount as payment in full (i.e., $144 ($160 x .90)). The plan also has a $50 deductible for physician services, which yet has not been satisfied in any part. Thus, the plan pays $34 ($144 preferred physician rate minus $50 deductible). The fee schedule amount for this treatment is $160. The Medicare secondary payment is calculated as follows:

1. The amount the physician is obligated to accept as payment in full minus the third party payment: $144 - $34 = $110.
2. Determine the Medicare payment in the usual manner: $150 - $110 x .80 = $120.
3. Employer plan’s allowable charge of $160 (which is higher than Medicare’s fee schedule amount of $150) minus the employer plan’s payment of $120 equals $40.

Pay $40 (lowest of amounts in steps 1, 2, or 3).

National Government Services, Common Electronic Data Interchange (CEDI) creates and delivers the following Level I reports for each claim file submitted:

- **TA1** (NOTE: Some systems may generate a TA1 report for accepted and rejected files, others will only generate a TA1 if the file rejects. Check with your software vendor to determine if your system generated both an accepted and/or rejected TA1.
- **TRN**
- **997**
- **GenResponse (GENRPT)**


Questions regarding rejections on the TA1, TRN and/or 997 should be directed to your software vendor. Your vendor will know what needs to be corrected in order to pass these edits. CEDI will provide support for the GenResponse (GENRPT) report.

Electronic trading partners/submitters will also receive a Level II report from each DME MAC Jurisdiction that received claims in the file(s) sent to CEDI. These Level II reports are created by the DME MACs and delivered by CEDI.


NOTE: Common Front End Edits (i.e. 20004, 20011, 20322, 40014 and many more) are listed in the DME MAC Front End Edit Error Code Manual. This manual provides the edit number/code, edit descriptions and edit explanations. Examples of these reports are included in the back of the manual.

Commonly asked questions on the Electronic Front End Reports are located in the CEDI Frequently Asked Questions (FAQ) document and can be accessed using the following link: [http://www.ngscedi.com/outreach_materials/outreachindex.htm](http://www.ngscedi.com/outreach_materials/outreachindex.htm).

CEDI created the resources referenced above to assist DME MAC electronic trading partners with understanding the electronic reports delivered.

Quacked Quote:

There are two kind of people: those that finish what they start, and
Participation in third-party plans has become a near necessity for many optometrists today. In addition to making good eye and vision care practical and affordable for many patients, insurance plans can be beneficial to optometric practices. They can potentially bring in new patients for a variety of services, albeit at reimbursement levels below those a practitioner may normally charge. Optometrists must carefully evaluate all insurance programs and then make well-considered business decisions regarding which plans can provide a benefit for the practice. Unfortunately, questions received by the AOA Eye Care Benefits Center (AOAIECBC) suggest many practitioners still do not totally understand how to assess participation in third-party plans.

To assist practitioners with this important task, the AOA has introduced a number of innovative, new services over recent months.

- The AOA Web site now features a new “Evaluating a Plan/Making a Business Decision” page, which provides detailed information on the assessment of insurance plans (www.aoa.org/x9268.xml).
- The Evaluating a Plan/Making a Business Decision Web page offers an interactive Chair Cost Calculator to help an optometrist determine how much it costs to provide care in a practice based on the optometrist’s individual expenses (www.aoa.org/x9619.xml).
- A recently introduced AOA Contract Analysis Service allows AOA members to have insurance plan contracts reviewed before they sign them. For information, see the AOA Contract Analysis Service Web page (www.aoa.org/contractanalysis.xml). In the most basic terms, the AOA-ECBC suggests a 3-step approach to the evaluation of participation in insurance programs:
  1. Know the insurance plan.
  2. Know the practice and how much it costs to provide care.
  3. Know the specifics of the contract being offered.

Find more, including downloadable forms, on the AOA web page http://www.aoa.org/x9268.xml.
CMS has identified problems of noncompliance with existing statutes, regulations, rules, and other systematic problems relating to standards of practice for a valid physician’s signature on medical orders and related medical documents. The Centers for Medicare & Medicaid Services (CMS) has taken steps to ensure accurate application of Medicare’s program requirements throughout the nation.

CR 5971 (Transmittal #248) was issued to prohibit the use of stamped signatures. These requirements are intended to apply all providers/suppliers. Stamped signatures are not acceptable on any medical record. Medicare will accept handwritten, electronic signatures or facsimiles of original written or electronic signatures.

In addition, the Medicare Conditions of Participation (CoP) are requirements for ensuring health and safety. The CoPs define specific quality standards that providers must meet to participate in the Medicare program. A provider’s compliance with the CoPs is ultimately determined by the CMS regional office based on the State survey agency recommendation (per the Medicare Program Integrity Manual, Publication 100-8, Chapter 3, Section 3.4.2.1, which is available at http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf on the CMS website). Compliance with the CoPs and any related policies does not necessarily ensure that certain requirements for payment are being met.

Source: MLN Matters Number: SE0829 Related Change Request Number: 5971

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**Dr. Quentin Quack’s Punny Humor**

Dr. Quack disowns, and assumes no responsibility for, the following...

1. Two antennas met on a roof, fell in love and got married. The ceremony wasn’t much, but the reception was excellent.
2. A jumper cable walks into a bar. The bartender says, ‘I’ll serve you, but don’t start anything.’
3. Two peanuts walk into a bar, and one was a salted.
4. A dyslexic man walks into a bra.
5. A man walks into a bar with a slab of asphalt under his arm and says: ‘A beer please, and one for the road.’
6. Two cannibals are eating a clown. One says to the other: “Does this taste funny to you?”
8. Two cows are standing next to each other in a field. Daisy says to Dolly, ‘I was artificially inseminated this morning.’ ‘I don’t believe you,’ says Dolly. ‘It’s true, no bull!’ exclaims Daisy
9. An invisible man marries an invisible woman. The kids were nothing to look at either.
10. Deja Moo: The feeling that you’ve heard this bull before.
11. I went to buy some camouflage trousers the other day, but I couldn’t find any.
12. A man woke up in a hospital after a serious accident. He shouted, ‘Doctor, doctor, I can’t feel my legs!’ The doctor replied, ‘I know you can’t - I’ve cut off your arms!’
13. I went to a seafood disco last week...and pulled a mussel.
15. Two fish swim into a concrete wall. The one turns to the other and says ‘Damn!’
16. Two Eskimos sitting in a kayak were chilly, so they lit a fire in the craft. Unsurprisingly it sank, proving once again that you can’t have your kayak and heat it too.
17. A group of chess enthusiasts checked into a hotel and were standing in the lobby discussing their recent tournament victories. After about an hour, the manager came out of the office and asked them to disperse. ‘But why?’ they asked, as they moved off. ‘Because,’ he said, ‘I can’t stand chess-nuts boasting in an open foyer.’
18. A woman has twins and gives them up for adoption. One of them goes to a family in Egypt and is named ‘Ahmal.’ The other goes to a family in Spain; they name him ‘Juan.’ Years later, Juan sends a picture of himself to his birth mother. Upon receiving the picture, she tells her husband that she wishes she also had a picture of Ahmal. Her husband responds, ‘They’re twins! If you’ve seen Juan, you’ve seen Ahmal!’
19. Mahatma Gandhi, as you know, walked barefoot most of the time, which produced an impressive set of calluses on his feet. He also ate very little, which made him rather frail, and with his odd diet, he suffered from bad breath. This made him……. A super calloused fragile mystic hexed by halitosis.
20. And finally, there was the person who sent twenty different puns to his friends, with the hope that at least ten of the puns would make them laugh. No pun in ten did.
Dear Dr. Quack,

We have a patient who comes in often (at least monthly) with extremely dry eyes, filamentary keratitis, and glaucoma, and has had glaucoma filtration surgery. The only relief she gets is with bandage contact lenses. I have been submitting just the office visit. But we are wondering if there isn’t a code for bandage contact lens that Medicare will pay and we should be using instead. I would appreciate your input.

Dr. Quack’s Quote:

Yes, the code for a bandage contact lens is 92070. It is coded alone; that is, you do not code an office visit in addition to the lens...the lens and visit are bundled together. Medicare currently reimburses $57.13.

Take a look at 92070 in your CPT-2008.

How to Prepare for a Record Review

Dear Dr. Quack:

We recently received a letter from Unicare, the Medicare Advantage Company, stating that they wanted to review 125 of our records. We don’t think we have done anything wrong, but we are concerned. What should we do to prepare...they are going to be here tomorrow.

Dr. Quack’s Quote:

First of all, don’t panic. Reviews seem scary, but rarely are anything of major concern. Unicare has apparently been very thorough in its review process over the state, and not just of optometrists. So I seriously doubt they are reviewing you for cause.

I would make the following suggestions for preparation, however:

1. Set aside a quiet, comfortable area for the reviewer to work, free from distractions, and large enough to lay out your records.

2. If you know which records are to be pulled, have them pulled in advance. (Under no circumstances should you alter or embellish these records...they must stand on their own. Altering records is a serious offense.)

3. On the other hand, if the reviewer is bringing the list of records to be reviewed with him/her, be prepared to pull the records quickly and efficiently.

4. Have a table of abbreviations used in your office readily available. If your doctors use different abbreviations, have a list of each doctor’s available.

5. If the reviewer has suggestions regarding your record keeping, both official and unofficial, be sure to listen carefully and write them down to pass on to others in your office, especially your doctors. It’s alright to explain to the reviewer any apparent misunderstanding s/he may have about your record keeping, but it is not productive to argue with the reviewer.

6. Above, all, be kind and courteous, even if the reviewer seems curt and abrupt. Remember, they have a very challenging job, and they are often working in a hostile environment. Common courtesy will go a long way in transmitting your concern about keeping accurate records.
DME ACCREDITATION LIKELY DROPPED FOR ODS
The AOA Washington Office has just learned that CMS officials have notified the National Supplier Clearinghouse (NSC) that “new” durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier applications from physicians, including ODs, will not require accreditation. Pg.1.

CMS ONLINE MANUAL SYSTEM (IOM)
The CMS Online Manual System offers day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives. Details provided. Pg.2.

2009 ICD-9-CM REQUIRED OCTOBER 1ST
CMS reminds providers that the annual ICD-9-CM update (to the 2009 edition) will be effective for dates of service on and after October 1, 2008 due to HIPAA regulations. Pg.3.

SIGN UP FOR WPS MEDICARE LISTSERV
The WPS Medicare Listserv allows you to get the most current Medicare news delivered right to your email account. Pg.3.

CMS-1500 TO ELECTRONIC CLAIMS CROSSWALK
For those who file electronically, there is a WPS source that explains where to insert the CMS-1500 data items into which electronic data loops. Pg.3.

CMS-855 MEDICARE ENROLLMENT APPLICATIONS REVISED
CMS reminds applicants that applications received on and after October 1, 2008 must be submitted on the 2008 versions of the CMS-855 forms. Pg.3.

HHS TAKES STEPS TO ACCELERATE ELECTRONIC PRESCRIPTIONING
Medicare is starting a new program to encourage physicians to adopt e-prescribing systems. Incentive payments will be available beginning in 2009 for physicians who meet the requirements of the program. Pg.3.

ONLINE LESSON REGARDING REFRACTIVE LENS CLAIMS
A coding lesson on Refractive Lenses is currently available at the Online Learning Center under the DME Coverage and Specialty course. Pg.4.

NORIDIAN DME: OUTSTANDING CLAIM INFO AVAILABLE BY PHONE
To access outstanding claim information (aka “payment floor” information) from the Noridian Interactive Voice Response (IVR) system, call 1-877-320-0390, and follow directions on Pg.4.

INFORMATION FOR EXPRESS PLUS SOFTWARE USERS
National Government Services, Common Electronic Data Interchange (CEDI) recently updated the Express Plus Manual. It contains important info for Express Plus users. Pg.5.

ITEMS WITH EY MODIFIER MUST BE FILED SEPARATELY
When submitting a claim to Medicare for items dispensed without a physician order, then the supplier must append the EY modifier to the HCPCS code and file all lines with the EY modifier on a separate claim that is limited to claim lines containing the EY modifier. Pg.5.

FILING MEDICARE SECONDARY PAYER (MSP) ELECTRONIC CLAIMS
Medicare requires providers to submit Medicare Secondary Payer (MSP) claims electronically. Details on MSP electronic claims are provided. Pp. 6-7.

ELECTRONIC SUBMITTERS SHOULD REVIEW CEDI REPORTS
Common Electronic Data Interchange (CEDI) creates and delivers Level I reports for each claim. These reports are important to DME electronic filers. Details on Pg.8.

COMPLETE ITEM 32 ON ALL CLAIMS WITH POS OTHER THAN 12
Claim Item 32 - enter the name, address, and ZIP Code of the service location for all services not furnished at home (not POS=12). Pg.8.

AOA: E-PRESCRIBING READINESS ASSESSMENT NOW ONLINE
Using an AOA resource, optometrists can now determine if they are ready to issue pharmaceutical prescriptions electronically. Pg.9.

AOA: EVALUATING PARTICIPATION IN INSURANCE PLANS
To assist practitioners in evaluating whether to participate in a plan, the AOA has introduced a number of innovative, new services over recent months. Pg.9.

MEDICAL DOCUMENTS REQUIRE A VALID PHYSICIAN’S SIGNATURE
Stamped signatures are not acceptable on any medical record. CMS has identified problems of noncompliance. Pg.9.

CODING BANDAGE CONTACT LENSES
Information on billing bandage contact lenses is provided. Pg11.

HOW TO PREPARE FOR A RECORD REVIEW
Suggestions on preparing for a record review by an insurer are provided by Dr. Quack. Pg.11.