Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The Centers for Medicare & Medicaid Services (CMS) has announced the single payment amounts for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The Press Release on this issue is at http://www.cms.gov/apps/media/press_releases.asp and a related fact sheet is at http://www.cms.gov/apps/media/fact_sheets.asp on the CMS website.

MLN Matters® Number: MM7066 Revised
Related Change Request (CR) #: 7066
Related CR Release Date: September 24, 2010
Effective Date: January 1, 2011
Related CR Transmittal #: R777OTN
Implementation Date: January 3, 2011

Durable Medical Equipment (DME) National Competitive Bidding (NCB) Implementation- Phase 11E: Remittance Advice (RA) and Medicare Summary Notice (MSN) Messages for Round One

Note: This article was updated on December 7, 2012, to reflect current Web addresses. This article was previously revised on December 7, 2011, to add a reference to MLN Matters® article MM7632 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7632.pdf) for the latest information about the competitive bidding single payment amounts for DMEPOS items. All other information remains the same.

Provider Types Affected

Providers and suppliers billing Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries who reside in Competitive Bidding Areas (CBAs).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7066 to alert providers that Medicare contractors are required to use the appropriate remark, reason and Medicare Summary Notice (MSN) messages when processing National Competitive Bidding (NCB) claims for the Round One Rebid, as noted in the *Key Points* section below. Make certain your billing staffs are aware of these changes.

Background

Round One of the DMEPOS Competitive Bidding Program was implemented on July 1, 2008, in 10 competitive bidding areas, as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Congress enacted a temporary delay in the competitive bidding program for Round One Competitive Bidding Areas. The law required CMS to terminate the existing contracts that were awarded in Round One and re-compete the contracts in 2009. MIPPA also excluded certain DMEPOS items and areas from competitive bidding and provided an exemption to the program for hospitals that furnish certain types of DMEPOS items to their own patients.

On January 16, 2009, CMS issued an interim final regulation with comment period that incorporates changes required by the MIPPA. This rule implements certain MIPPA provisions that delay implementation of Round One of the Competitive Bidding Program and required CMS to conduct a second Round One competition (the Round One rebid) in 2009 and mandated certain changes for both the Round One rebid and subsequent rounds of the program. CR 7066 instructs Medicare contractors to use specific Medicare Summary Notices (MSN), which go to beneficiaries, and Remittance Advice (RA) messages for providers/suppliers for specific circumstances when processing NCB claims. Those RA messages are the subject of this article.

Key Points of CR 7066

The following points detail the messages that providers and suppliers may receive as a result of the DME NCB implementation as discussed in CR 7066:

1. On remittance advice messages for claims paid for beneficiaries residing in a CBA and obtaining an item from a contract supplier in their CBA, you will receive the following, as appropriate:

    - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

2. When denying a claim for a beneficiary who resides in a CBA who obtains an item from a non-contract supplier that has not obtained a signed Advance Beneficiary Notice (ABN), you will receive the following:

    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - 96 – Non-covered charge(s).
    - N211 – Alert: You may not appeal this decision.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

3. When a supplier has collected more than the 20 percent co-pay and any remaining deductible for an NCB claim, you will receive the following:

    - MA59 - Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
    - N211 – Alert: You may not appeal this decision.

4. When a claim is denied for an NCB item obtained from a non-contract supplier when the supplier has obtained an ABN, the following messages are used:

    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.

- 96 – Non-covered charge(s).
- N211 – Alert: You may not appeal this decision.
- M38 - The patient is liable for the charges for this item/service. The patient was informed in writing before the service was furnished that CMS would not pay for the item/service, and the patient agreed to pay by signing the Advanced Beneficiary Notice (ABN).

5. When a beneficiary from a CBA travels to a different CBA and obtains an NCB item from a contract supplier in that CBA, the following messages are returned for the paid claim:
    - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
6. When a beneficiary from a CBA travels to an area that is not designated as a CBA, the following messages accompany the paid claim:
    - M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
7. When Medicare makes payment to a non-contract supplier at the bid price on a grandfathered claim, the following messages are used:

- M112 - Reimbursement or this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.
- M113 – Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

8. The following messages are used when payment is made to a non-contract supplier at the fee schedule amount on a grandfathered claim for inexpensive and routinely purchased (IRP) items or capped rental base equipment:

    - M113 – Our records indicate that this patient began using this item/service prior to the current contract period for DMEPOS Competitive Bidding Program.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

9. When claims from physicians or hospitals acting as DMEPOS suppliers and there is no matching office visit found in Medicare claims history, the claims are denied using the following:

    - B15 - Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.

- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

10. When beneficiary-submitted claims that are subject to NCB are denied, the following messages are used:
    - 111 – Not covered unless the provider accepts assignment.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - N211 – Alert: You may not appeal this decision.
11. Paper claims subject to NCB are denied using the following messages:
    - A1 – Claim/Service Denied.
    - M117 – Not covered unless submitted via electronic claim.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - N211 – Alert: You may not appeal this decision.
12. Medicare will deny claims from Skilled Nursing Facilities (SNF) when the SNF acts as a limited contract supplier, but the place of service does not indicate a SNF. In denying such claims, the following messages are used:
    - 170 – Payment is denied when performed/billed by this type of provider.
    - M77 – Missing/incomplete/invalid place of service.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.

- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

13. The following messages are used by Medicare when making payments for oxygen in situations where the beneficiary does not use a grandfathered supplier, so that when the 36-month payment cap under the Deficit Reduction Act (DRA) has been reached, the cap must be increased for a total of up to 45 payments:

    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

14. The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for oxygen equipment when the payment cap has been reached:

    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N211 – Alert: You may not appeal this decision.
    - N370 – Billing exceeds the rental months covered/approved by the payer.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.

15. The following messages are used by Medicare when making payments for capped rental situations where the beneficiary does not use a grandfathered supplier, so that a total maximum of up to 25 payments will be made:

    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other

Demonstration Project. For more information regarding this project, contact your local contractor.

- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

16. The following message is used when Medicare returns unassigned NCB claims as unprocessable:
    - 111 – Not covered unless the provider accepts assignment.
17. The following messages are used by Medicare when denying claims under NCB where a supplier submits a claim for a capped rental item when the payment cap has been reached :
    - B7: This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N370: Billing exceeds the rental months covered/approved by the payer.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
    - N211-Alert: You may not appeal this decision.
18. Medicare uses the following messages to deny claims when a modifier required for NCB is missing from a claim line:
    - 4 – The procedure code is inconsistent with the modifier use or a required modifier is missing.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
19. Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for both the base oxygen equipment and

the related oxygen contents received from a non-contract supplier when the rental period for the base oxygen equipment began on or after the start date of the Round One Rebid:

- 96 – Non-covered charge(s).
- M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
- M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- N211 – Alert: You may not appeal this decision.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

20. Medicare uses the following messages when denying oxygen content claims from a non-contract supplier that is not the same non-contract supplier that received the 36th month base oxygen equipment rental payment, when the initial date on the Certificate of Medical Necessity (CMN) for the base oxygen equipment is prior to the start date of the Round One Rebid and the CBA-residing beneficiary is not traveling:

    - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
    - N211 – Alert: You may not appeal this decision.
    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

21. Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for portable oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the stationary oxygen equipment prior to the start of the National

Competitive Bid Round One Rebid (the stationary oxygen equipment is not a grandfathered item):

- 96 – Non-covered charge(s).
- M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
- M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- N211 – Alert: You may not appeal this decision.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

22. Medicare uses the following messages when denying claims for a beneficiary residing in a CBA for stationary oxygen equipment that is acquired on or after the start date for the Round One Rebid, when submitted by a non-contract supplier, if the supplier did not furnish the portable oxygen equipment prior to the start of the National Competitive Bid Round One Rebid (the portable oxygen equipment is not a grandfathered item):

    - 96 – Non-covered charge(s).
    - M115 – This item is denied when provided to this patient by a non-contract or non-demonstration supplier.
    - M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
    - N211 – Alert: You may not appeal this decision.
    - MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

23. Medicare uses the following messages when denying claims for replacement of an item that is subject to the DMEPOS Competitive Bidding Program when submitted by non-contract suppliers, even when submitted with the "RA" modifier:

    - 96 – Non-covered charge(s).

- M115 – This item is denied when provided to the patient by a non-contract or non-demonstration supplier.
- M114 – This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or other Demonstration Project. For more information regarding this project, contact your local contractor.
- N211 – Alert: You may not appeal this decision.
- MA13 – Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

Note: For all the above situations, Medicare contractors assign a Group Code of "CO" – Contractual Obligation.

Additional Information

If you have questions, please contact your Medicare DME MAC at their toll-free number which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

The official instruction associated with this CR7066 issued to your Medicare DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R777OTN.pdf on the CMS website.

To review the CMS DME website that provides a complete listing of links to DME related information you may go to http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.htmlon the CMS website.

For discussion of the program instructions designating the competitive bidding areas and product categories included in the DMEPOS competitive bidding program round one rebid in CY 2009 you may review MM6571 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6571.pdf on the CMS website.

The MSAs and product categories that are included in the DMEPOS Competitive Bidding Round I rebid in 2009 can also be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website.

Further information on the boundaries and list of zip codes for each CBA and the Healthcare Common Procedure Coding System (HCPCS) codes for each product category are available by visiting http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html on the CMS website

and following the link to the Competitive Bidding Implementation Contractor (CBIC).

To review Round One Rebid of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program - Phase 8A: Hospital Exception you may go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6677.pdf on the CMS website.