DME Happenings

Jurisdiction D

June 2017

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CLAIMS REVIEW

This Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no-cost from our website at: http://www.med.noridianmedicare.com

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noridian Healthcare Solutions

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

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Sources for "DME Happenings" Articles

The purpose of "DME Happenings" is to educate Noridian's Durable Medical Equipment supplier community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes "Source" following CMS derived articles to allow for those interested in the original material to research it at CMS's website, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 am – 8 pm CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status
Supplier Contact Center	1-877-320-0390	8 am – 6 pm CT Monday-Friday
Telephone Reopenings	1-877-320-0390	8 am – 4:30 pm CT
Beneficiary Customer Service	1-800-633-4227	24 hours a day / 7 days a week
Website: www://med.noridianmedicare.com/web/jadme		
Fax		
Reopenings and Redeterminations DME Recovery Auditor Redeterminations		1-701-277-7886
Refunds to Medicare Immediate Offsets		1-701-277-7894
MSP Inquiries and Refunds		1-701-277-7892
DME Recovery Auditor Offsets		1-701-277-7896
Medical Review Medical Documentation		1-701-277-7888
NHS Email Addresses		
NHS DME Customer Service		https://med.noridianmedicare.com/web/jddme/contact/email-customer-service
Reopenings and Redeterminations		dmeredeterminations@noridian.com
Noridian JD Website		https://med.noridianmedicare.com/web/jddme
Mailing Addresses		

Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation, Recovery Auditor Overpayments Noridian JD DME Attn: _____ PO Box 6727 Fargo, ND 58108-6727	**Benefit Protection, Administrative Simplification Compliance Act Exception Requests (ASCA)** Noridian JD DME Attn: Benefit Protection PO Box 6736 Fargo, ND 58108-6736
Qualified Independent Contractor C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville, FL 32231-4013	**Electronic Funds Transfer Forms/ Overpayment Redeterminations/ DME Recovery Auditor Redeterminations** Noridian JD DME Attn: _____ PO Box 6728 Fargo, ND 58108-6728

Other DME MACs and Other Resources

Noridian: Jurisdiction A	866-419-9458	https://med.noridianmedicare.com/web/jadme
CGS: Jurisdiction B	877-299-7900	www.cgsmedicare.com
CGS: Jurisdiction C	866-238-9650	www.cgsmedicare.com
Pricing, Data Analysis and Coding (PDAC)	877-735-1326	www.dmepdac.com
National Supplier Clearinghouse	866-238-9652	www.palmettogba.com/nsc
Common Electronic Data Interchange (CEDI) Help Desk	866-311-9184	www.ngscedi.com
Centers for Medicare and Medicaid Services (CMS)		www.cms.gov

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

Source: Internet Only Manual, Publication 100-8, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

Organization	Phone Number	Types of Inquiries
1-800-MEDICARE	1-800-633-4227	General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary
Social Security Administration	1-800-772-1213	Changing address, replacement Medicare card and Social Security Benefits
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare
Coordination of Benefits	1-800-999-1118	Reporting changes in primary insurance information

Another great resource for beneficiaries is the website, http://www.medicare.gov/, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for and access MyMedicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

Source: Internet Only Manual (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 20, Section 200

CERT Documentation

This article is to remind suppliers they must comply with requests from the Comprehensive Error Rate Testing (CERT) Documentation Contractor for medical records needed for the CERT program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT Documentation Contractor sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT Documentation Contractor will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is 804-261-8100.

Mail all requested documentation to:

AdvanceMed
CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT Documentation Contractor at 888-779-7477 with questions regarding specific documentation to submit.

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT Documentation Contractor.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from Noridian as the services for which there is no documentation are interpreted as services not rendered.

CMS Quarterly Provider Updates

The Quarterly Provider Update is a listing of non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers or suppliers. This comprehensive resource is published by CMS on the first business day of each quarter. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

Extension of the Transition to the Fully Adjusted DMEPOS Payment Rates for 21st Century Cures Act Mass Adjustments

CMS has issued Change Request (CR) 9968 and related contractor instructions to begin mass adjustments for all claims impacted by the extension of the transition to the fully adjusted Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) payment rates under Section 16007 of the 21st Century Cures Act.

Noridian is prepared to begin mass adjustments to all claims covered under the rule and will be initiating adjustments for 20,000 claims each day for Jurisdiction A and 20,000 claims for Jurisdiction D for the next 24 weeks as directed by CMS.

As part of the fee schedule update for the 21st Century Cures Act, the KE modifier was added to the fee schedule for use on items bid under the initial Round 1 of Competitive Bidding but used with non-competitive bid base equipment. Suppliers must request written or telephone reopenings to add the KE modifier to applicable claims after the mass adjustments are complete.

Noridian will notify suppliers through an article and listserv message when all the claims have been adjusted so that reopenings to add the KE modifier can be requested. The article and list serve will provide detailed instructions for the KE modifier reopening process.

If a KE modifier adjustment request is submitted before this notice is published, the request will be dismissed and you will be asked to resubmit when appropriate.

For more information, see CMS Medicare Learning Network (MLN) Matters (MM) 9968.

Same or Similar Reference Chart Updated

The Same or Similar Reference Chart assists suppliers in understanding same or similar denials. The reference chart has been updated to include Orthotics and Prosthetic items such as Ankle/Foot Orthosis, Knee Orthoses and Therapeutic Shoes in addition to the DME items being currently tracked.

The chart contains the same and similar HCPCS category items when they exist. This chart should be used when inquiring on Same or Similar and Same or Same in the Noridian Medicare Portal (NMP) and the Interactive Voice Response (IVR).

View the complete Same or Similar Reference Chart on the Noridian website.

DMEPOS Order Requirements for Changing Suppliers

MLN Matters® Number: MM9886

Related Change Request (CR) #: CR 9886

Related CR Release Date: March 24, 2017

Effective Date: April 24, 2017

Related CR Transmittal #: R705PI

Implementation Date: April 24, 2017

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What You Need to Know

Change Request (CR) 9886 instructs MACs to accept timely orders and medical documentation (so long as it meets Medicare requirements), regardless of whether the supplier received the documentation directly from the beneficiary's eligible practitioner or from another, transferring supplier. Be aware that a new order is required in the following situations:

There is a change in the order for the accessory, supply, drug, and so forth

On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy.

When an item is replaced.

When there is a change in the supplier, if the recipient supplier did not obtain a valid order for the DMEPOS item from the transferring supplier.

Background

The DMEPOS Competitive Bidding Program (CBP) uses competition among suppliers to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, while ensuring beneficiary access to quality items and services. Industry suggests that competition is bolstered and provider burden limited by allowing suppliers to accept medical documentation from other suppliers who previously held responsibility for that beneficiary. This change in the Centers for Medicare & Medicaid Services (CMS) instruction would permit MACs to accept timely orders and medical documentation, regardless of whether the supplier received the documentation directly from the beneficiary's eligible practitioner or from a transferring supplier. This change is applicable to all suppliers.

Additional Information

The official instruction, CR9886, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R705PI.pdf.

Further information about the DMEPOS Competitive Bidding Program is available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.

Common Working File MSP Type for Liability Medicare Set-Aside Arrangements and No-Fault Medicare Set-Aside Arrangements – Revised

MLN Matters® Number: MM9893 Revised

Related Change Request (CR) #: CR 9893

Related CR Release Date: May 10, 2017

Effective Date: October 1, 2017

Related CR Transmittal #: R1845OTN

Implementation Date: October 2, 2017

This article was revised on May 10, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on CR 9893. To comply with the Government Accountability Office (GAO) final report entitled Medicare Secondary Payer (MSP): Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans (GAO 12-333), the Centers for Medicare & Medicaid Services (CMS) will establish two (2) new set-aside processes: a Liability Insurance Medicare Set-Aside Arrangement (LMSA), and a No-Fault Insurance Medicare Set-Aside Arrangement (NFMSA). An LMSA or an NFMSA is an allocation of funds from a liability or an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare.

Please be sure your billing staffs are aware of these changes.

Background

CMS will establish two (2) new set-aside processes: a Liability Medicare Set-aside Arrangement (LMSA), and a No-Fault Medicare Set-aside Arrangement (NFMSA).

CR 9893 addresses (1) the policies, procedures, and system updates required to create and utilize an LMSA and an NFMSA MSP record, similar to a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) MSP record, and (2) instructs the MACs and shared systems when to deny payment for items or services that should be paid from an LMSA or an NFMSA fund.

Pursuant to 42 U.S.C. Sections 1395y(b)(2) and 1862(b)(2)(A)(ii) of the Social Security Act, Medicare is precluded from making payment when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance." Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA or NFMSA funds. However, Liability and No- Fault MSP claims that do not have a Medicare Set-Aside Arrangement (MSA) will continue to be processed under current MSP claims processing instructions.

Key Points of CR9893

Medicare will not pay for those services related to the diagnosis code (or related within the family of diagnosis codes) associated with the open LMSA or NFMSA MSP record when the claim's date of service is on or after the MSP effective date and on or before the MSP termination date. Your MAC will deny such claims using Claim Adjustment Reason Code (CARC) 201 and Group Code "PR" will be used when denying claims based on the open LMSA or NFMSA MSP auxiliary record.

In addition to CARC 201 and Group Code PR, when denying a claim based upon the existence of an open LMSA or NFMSA MSP record, your MAC will include the following Remittance Advice Remark Codes (RARCs) as appropriate to the situation:

- N723 - Patient must use Liability Set Aside (LSA) funds to pay for the medical service or item.
- N724 - Patient must use No-Fault Set-Aside (NFSA) funds to pay for the medical service or item.

Where appropriate, MACs may override and make payment for claim lines or claims on which:

Auto/no-fault insurance set-asides diagnosis codes do not apply, or

Liability insurance set-asides diagnosis codes do not apply, or are not related, or

When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR9009.

On institutional claims, if the MAC is attempting to allow payment on the claim, the MAC will include an "N" on the '001' Total revenue charge line of the claim.

Additional Information

The official instruction, CR9893, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1845OTN.pdf.

The GAO report related to this issue is available at http://www.gao.gov/products/GAO-12-333.

CR9009 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R113MSP.pdf.

The Process of Prior Authorization – Revised

MLN Matters® Number: MM9940 Revised

Related Change Request (CR) #: CR 9940

Related CR Release Date: January 20, 2017

Effective Date: February 21, 2017

Related CR Transmittal #: R698PI

Implementation Date: February 21, 2017

This article was revised on May 1, 2017, to include a new Web address for the Required Prior Authorization List. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers ordering certain DMEPOS items and suppliers submitting claims to Medicare Administrative Contractors (MACs) for items furnished to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9940 updates the Centers for Medicare & Medicaid Services (CMS) "Program Integrity Manual" to permit the MACs to conduct prior authorization processes, as so directed by CMS through individualized operational instructions. As of January 2017, Prior Authorization of Certain Durable Medical Equipment, Prosthetic, Orthotic, and Supply Items, frequently subject to unnecessary utilization,

is the only permanent (non-demonstration) prior authorization program approved for implementation. Make sure your billing staff is aware of these changes.

Background

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted to a medical review contractor for review before the item or service is furnished to the beneficiary and before the claim is submitted for processing. It is a process that permits the submitter/requester (for example, provider, supplier, beneficiary) to send in medical documentation, in advance of the item or service being rendered, and subsequently billed, in order to verify its eligibility for Medicare claim payment.

For any item or service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category
- Be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Meet all other applicable Medicare coverage, coding and payment requirements

Contractors shall, at the direction of CMS or other authorizing entity, conduct prior authorizations and alert the requester/submitter of any potential issues with the information submitted.

A prior authorization request decision can be either a provisional affirmative or a non-affirmative decision.

- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements.
- A non-affirmative decision is a finding that the submitted information/ documentation does not meet Medicare's coverage, coding, and payment requirements, and if a claim associated with the prior authorization is submitted for payment, it would not be paid. MACs shall provide notification of the reason for the non-affirmation, if a request is non-affirmative, to the submitter/requester. If a prior authorization request receives a non-affirmative decision, the prior authorization request can be resubmitted an unlimited number of times.
- Prior authorization may also be a condition of payment. This means that claims submitted without an indication that the submitter/requester received a prior authorization decision (that is, Unique Tracking Number (UTN)) will be denied payment.

Each prior authorization program will have an associated Operational Guide that will be available on the CMS website. In addition, MACs will educate stakeholders each time a new prior authorization program is launched. That education will include the requisite information and timeframes for prior authorization submissions and the vehicle to be used to submit such information to the MAC.

Prior Authorization Program for DME MACs

A prior authorization program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization is described in 42 CFR 414.234. Among other things, this section establishes a Master List of certain DMEPOS items meeting inclusion criteria and potentially subject to prior authorization. CMS will select Healthcare Common Procedure Coding System (HCPCS) codes from the Prior Authorization Master List to be placed on the Required Prior Authorization List, and such codes will be subject to prior authorization as a condition of payment. In selecting HCPCS codes, CMS may consider factors such as geographic location, item utilization or cost, system capabilities, administrative burden, emerging trends, vulnerabilities identified in official agency reports, or other data analysis.

- The Prior Authorization Master List is the list of DMEPOS items that have been identified using the inclusion criteria described in 42 CFR 414.234.
- The List of Required DMEPOS Prior Authorization Items contains those items selected from the Prior Authorization Master List to be implemented in the Prior Authorization Program. The List of Required DMEPOS Prior Authorization Items will be updated as additional codes are selected for prior authorization.
- CMS may suspend prior authorization requirements generally or for a particular item or items at any time and without undertaking rulemaking. CMS provides notification of the suspension of the prior

authorization requirements via Federal Register notice and posting on the CMS prior authorization website.

The items on the Required Prior Authorization List, a "CMS Final Rule 6050-F" subpage containing the Master List, as well as other pertinent information and supporting documents regarding this program, are available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html.

Additional Information

The official instruction, CR9940, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R698PI.pdf.

DMEPOS Fee Schedule - April 2017 Update – Revised

MLN Matters® Number: MM 9988 Revised

Related Change Request (CR) #: CR9988

Related CR Release Date: May 5, 2017

Effective Date: April 1, 2017

Related CR Transmittal #: R3768CP

Implementation Date: April 3, 2017

This article was revised on May 5, 2017, to reflect a revised CR9988 issued that day. The CR was revised to delete an example that was in the original CR. That example has been removed from the article. Also, the CR release date, transmittal number, and the Web address of CR9988 are revised in the article. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

What You Need to Know

Change Request (CR) 9988 provides the April 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual" (Pub.100-04, Chapter 23, Section 60).

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (§1834(a), (h), and (i)). Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 §414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section §1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural

payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

The Calendar Year (CY) 2017 DMEPOS and PEN fee schedules and the April 2017 DMEPOS Rural ZIP code file public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions

Section 16005 of the 21st Century Cures Act extends the effective date through June 30, 2017, to exclude adjustments to fees using information from CBPs for certain wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). As a result, the KU modifier fees have been added back to the DMEPOS fee schedule file effective January 1, 2017, and are effective for dates of service through June 30, 2017. The fees for items denoted with the HCPCS modifier 'KU' represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated by the 2016 and 2017 DMEPOS covered item update factor of 0.7 percent). The applicable complex rehabilitative wheelchair accessory codes are listed in CR 9520 (Transmittal 3535, dated June 7, 2016).

Note for Change Request 8822 Reclassification of Certain DME to the Capped Rental Payment Category

For dates of service on or after January 1, 2017, payment for the following HCPCS codes in all geographic areas is made on a capped rental basis: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, through December 31, 2016, these HCPCS codes were reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the nine Round 1 Recompete (Round 1 2014) Competitive Bidding Areas (CBAs). Program instructions on these changes were issued in CR 8822 (Transmittal 1626, dated February 19, 2016) and CR 8566 (Transmittal 1332, dated January 2, 2014). Related MLN Matters articles are at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8822.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8566.pdf, respectively.

When submitting claims, suppliers that submit claims with more than four modifiers including when the claim is being billed with both the RT (right) and the LT (left) modifiers will include the NU (Purchase of new equipment) or RR (Rental) modifier as appropriate, the RT and LT modifiers and then the 99 modifier to signify that there are additional modifiers in use. On the narrative line, the supplier will include all applicable modifiers including the NU or RR, RT and LT modifiers.

Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment

CR 9848 (Transmittal 3679, dated December 16, 2016) titled Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment, updated the "Medicare Claims Processing Manual" (Pub.100-04, chapter 20, section 130.6) to clarify billing when the prescribed amount of stationary oxygen exceeds 4 liters per minute (LPM) and portable oxygen is prescribed. The QF modifier is used to denote when the oxygen flow exceeds 4 LPM and portable oxygen is prescribed.

The Social Security Act (§ 1834(a)(5)(C) and (D)) requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1392) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392, or K0738), and never both.

To facilitate this payment calculation, the QF modifier is added to the DMEPOS fee schedule file effective

April 1, 2017, for both stationary and portable oxygen. The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen QF fee schedule amounts represent the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on amount.

Effective April 1, 2017, the modifier "QF" should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 liters per minute (LPM).

Additional Information

To view the official instruction, CR 9982 issued to your MAC regarding this change, refer https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3768CP.pdf.

DMEPOS CBP - July 2017 Update

MLN Matters® Number: MM10004

Related Change Request (CR) #: CR 10004

Related CR Release Date: March 10, 2017

Effective Date: July 1, 2017

Related CR Transmittal #: R3733CP

Implementation Date: July 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for DMEPOS provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 10004 provides the DMEPOS CBP July 2017 quarterly update. The CR provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Note that quarterly updates are available on the DMEPOS Competitive Bidding Program (CBP). To review the updates, select (click) on the quarterly updates link on the left of the page.

Background

The DMEPOS CBP was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services. Under the program Medicare conducts a competition among suppliers who operate in a particular Competitive Bidding Area. Suppliers must submit a bid for selected products. Note that not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process and required documents are mailed. Bids are evaluated based on the eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

Additional Information

To view the official instruction, CR 10004 issued to your MAC regarding this change, refer https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3733CP.pdf.

The DMEPOS CBP site DME CB includes information on all rounds of the CBP, including product categories, single payment amounts, and the ZIP codes of areas included in the CBP.

ASP Medicare Part B Drug Pricing Files and Revision to Prior Quarterly Pricing Files – July 2017

MLN Matters Number: MM10016

Related Change Request (CR) Number: 10016

Related CR Release Date: April 7, 2017

Effective Date: July 1, 2017

Related CR Transmittal Number: R3746CP

Implementation Date: July 3, 2017

Provider Type Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9945 provides the July 2017 quarterly update and instructs MACs to download and implement the July 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised April 2017, January 2017, October 2016, and July 2016 Average Sales Price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after July 3, 2017, with dates of service July 1, 2017, through September 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and Not Otherwise Classified (NOC) drug-pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions.

The following files are related to this most recent update:

- July 2017 ASP and ASP NOC – Effective Dates of Service: July 1, 2017, through September 30, 2017
- April 2017 ASP and ASP NOC – Effective Dates of Service: April 1, 2017, through June 30, 2017
- January 2017 ASP and ASP NOC – Effective Dates of Service: January 1, 2017, through March 31, 2017
- October 2016 ASP and ASP NOC – Effective Dates of Services: October 1, 2016, through December 31, 2016
- July 2016 ASP and ASP NOC – Effective Dates of Service: July 1, 2016, through September 30, 2016

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the "Medicare Claims Processing Manual," Chapter 17, Section 20.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf.

For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

Additional Information

The official instruction issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3746CP.pdf.

DMEPOS Fee Schedule – July 2017 Update

MLN Matters Number: MM10071
Related Change Request (CR) # 10071
Related CR Release Date: April 28, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3760CP
Implementation Date: July 3, 2017

Provider Type Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

Provider Action Needed

Change Request (CR) 10071 provides the July 2017 quarterly update for the Medicare DMEPOS fee schedule, and it includes information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual, Chapter 23, Section 60 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic

devices, orthotics, prosthetics and surgical dressings by the Social Security Act. Section 1834 at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

Also, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 for parenteral and enteral nutrition (PEN), splints and casts and intraocular lenses (IOLs) inserted in a physician's office.

Additionally, Section 1834 of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas (CBAs), based on information from competitive bidding programs (CBPs) for DME. The Social Security Act (§1842(s)(3)(B)) provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs. Also, the adjusted fees apply a rural payment rule. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjustments as well as codes that are not subject to the fee schedule adjustments. Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 9642 (Transmittal 3551, dated June 23, 2016).

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

The Calendar Year (CY) 2017 DMEPOS and PEN fee schedules and the July 2017 DMEPOS Rural ZIP code file public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back

Cushions

Effective July 1, 2017, the fee schedule amounts for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are deleted from the DMEPOS fee schedule file. These unadjusted fee schedule amounts have applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864). The fee schedule amounts associated with the KU modifier were mandated by Section 2 of Patient Access and Medicare Protection Act (PAMPA) effective for dates of service January 1, 2016 through December 31, 2016. Additionally, section 16005 of the 21st Century Cures Act extended the effective date through June 30, 2017. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 dated June 7, 2016.

Therapeutic Continuous Glucose Monitor (CGM)

As part of this update, the fee schedule amounts for the following therapeutic CGM HCPCS codes are added to the DMEPOS fee schedule file effective for dates of service on or after July 1, 2017:

- K0553 - Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month's supply
- K0554 - Receiver (monitor), dedicated, for use with therapeutic continuous glucose monitor system

The fee schedule amounts apply a CMS Ruling effective on or after January 12, 2017 for therapeutic CGMs. Additional information on the CMS Ruling is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf.

Additional information

The official instruction, CR10071, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3760CP.pdf.

HCPCS Drug/Biological Code Changes – July 2017 Update

MLN Matters Number: MM10107

Related Change Request (CR) Number: CR 10107

Related CR Release Date: May 18, 2017

Effective Date: July 1, 2017

Related CR Transmittal Number: R3776CP

Implementation Date: July 3, 2017

Provider Types Affected

This MLN Matters Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need To Know

The HCPCS code set is updated on a quarterly basis. Change Request (CR) 10107 informs MACs of updating specific drug/biological HCPCS codes. Beginning on July 1, 2017, the HCPCS file will include the following new codes:

- Q9984:
  - Short Description: Kyleena
  - Long Description: Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg
  - Type of Service (TOS) Code 9
- Q9985
  - Short Description: Inj, hydroxyprogesterone, NOS

- Long Description: Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg
- TOS Code 1, P

- Q9986
  - Short Description: Inj, Makena
  - Long Description: Injection, hydroxyprogesterone caproate (Makena), 10 mg
  - TOS Code 1, P
- Q9988
  - Short Description: Platelets, pathogen reduced
  - Long Description: Platelets, pathogen reduced, each unit
  - TOS Code 9
- Q9989
  - Short Description: Ustekinumab IV Inj, 1 mg
  - Long Description: Ustekinumab, for Intravenous Injection, 1 mg
  - TOS Code 1, P

Also, beginning on July 1, 2017, HCPCS code J1725 (Injection, hydroxyprogesterone caproate, 1 mg) is no longer payable for Medicare.

Make sure your billing staffs are aware of these changes.

ADDITIONAL INFORMATION

The official instruction, CR10107, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3776CP.pdf.

Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program – Third Revision

MLN Matters® Number: SE1128 Revised

Release Date of Revised Article: May 12, 2017

This article was revised on May 12, 2017, to modify language pertaining to billing beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program. All other information is the same.

Provider Types Affected

This article pertains to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.

What You Need to Know

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. QMB is a Medicare Savings Program (MSP) that exempts Medicare beneficiaries from Medicare cost-sharing liability.

The QMB program is a State Medicaid benefit that covers Medicare premiums and deductibles, coinsurance, and copayments, subject to State payment limits. (States may limit their liability to providers for Medicare deductibles, coinsurance, and copayments under certain circumstances.) Medicare providers may not bill QMB individuals for Medicare cost-sharing, regardless of whether the State reimburses providers for the full Medicare cost-sharing amounts. Further, all original Medicare and MA providers--not only those that accept Medicaid--must refrain from charging QMB individuals for Medicare cost-sharing. Providers who inappropriately bill QMB individuals are subject to sanctions.

Refer to the Background and Additional Information Sections of this article for further details and resources about this guidance. Please ensure that you and your staff are aware of the Federal billing law and policies regarding QMB individuals. Contact the Medicaid Agency in the States in which you practice to learn about ways to identify QMB patients in your State and procedures applicable to Medicaid reimbursement for their Medicare cost-sharing. If you are a MA provider, you may also contact the MA plan for more information. Finally, all Medicare providers should ensure that their billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

Background

This article provides CMS guidance to Medicare providers to help them avoid inappropriately billing QMBs for Medicare cost-sharing, including deductibles, coinsurance, and copayments.

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers from billing a QMB beneficiary under any circumstances. See Section 1902(n)(3)(B) of the Social Security Act (the Act), as modified by Section 4714 of the Balanced Budget Act of 1997. QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, States can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

Medicare providers must accept the Medicare payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Inappropriate Billing of QMB Individuals Persists

Despite Federal law, improper billing of QMB individuals persists. Many beneficiaries are unaware of the billing restrictions (or concerned about undermining provider relationships) and simply pay the cost-sharing amounts. Others may experience undue distress when unpaid bills are referred to collection agencies. For more information, refer to Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), Centers for Medicare & Medicaid Services July 2015.

Important Clarifications Concerning the QMB Billing Law

Be aware of the following policy clarifications to ensure compliance with QMB billing requirements.

- All original Medicare and MA providers--not only those that accept Medicaid--must abide by the billing prohibitions.
- QMB individuals retain their protection from billing when they cross State lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different State than the State in which care is rendered.
- Note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

Ways to Improve Processes Related to QMBs

Proactive steps to identify QMB individuals you serve and to communicate with State Medicaid Agencies (and MA plans if applicable), can promote compliance with QMB billing prohibitions.

1. Determine effective means to identify QMB individuals among your patients, such as finding out the cards that are issued to QMB individuals, so you can in turn ask all your patients if they have them. Learn if you can query State systems to verify QMB enrollment among your patients. MA providers should contact the plan to determine how to identify the plan's QMB enrollees. Beginning October 1, 2017, you will be able to readily identify the QMB status of your patients with new Medicare Fee-For-Services improvements. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.

2. Determine the billing processes that apply to seeking reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided

to QMB beneficiaries. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

- If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.
- Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

3. Ensure that your billing software and administrative staff exempt QMB individuals from Medicare cost-sharing billing and related collection efforts.

QMB Eligibility and Benefits

Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits
QMB Only	≤100% of Federal Poverty Line (FPL)	≤3 times SSI resource limit, adjusted annually in accordance with increases in Consumer Price Index	Part A***	Not Applicable	Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)
Program	Income Criteria*	Resources Criteria*	Medicare Part A and Part B Enrollment	Other Criteria	Benefits

QMB Plus	≤100% of FPL	Determined by State	Part A***	Meets financial and other criteria for full Medicaid benefits	• Full Medicaid coverage • Medicaid pays for Part A (if any) and Part B premiums, and may pay for deductibles, coinsurance, and copayments to the extent consistent with the Medicaid State Plan (even if payment is not available under the State plan for these charges, QMBs are not liable for them)

* States can effectively raise these Federal income and resources criteria under Section 1902(r)(2) of the Act.

*** To qualify as a QMB or a QMB plus, individuals must be enrolled in Part A (or if uninsured for Part A, have filed for premium-Part A on a "conditional basis"). For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System.

Additional Information

For more information about dual eligibles under Medicare and Medicaid, please visit https://www.medicaid.gov/affordable-care-act/dual-eligibles/index.html and https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html and refer to Dual Eligible Beneficiaries Under Medicare and Medicaid. For general Medicaid information, please visit http://www.medicaid.gov/index.html.

Provider Enrollment Revalidation – Cycle 2 – Revised

MLN Matters® Number: SE1605 Revised

This article was revised on April 10, 2017, to correct the table on page 6. The last row should have stated the date as " November 29 – December 14, 2017." All other information is unchanged.

Provider Types Affected

This Medicare Learning Network (MLN) Matters® Special Edition Article is intended for all providers and suppliers who are enrolled in Medicare and required to revalidate through their Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs (HH&H MACs), Medicare Carriers, Fiscal Intermediaries, and the National Supplier Clearinghouse (NSC)). These contractors are collectively referred to as MACs in this article.

Provider Action Needed

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. The Centers for Medicare & Medicaid Services (CMS) has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. In an effort to streamline the revalidation process and reduce provider/supplier burden, CMS has implemented several revalidation processing improvements that are captured within this article.

Special Note: The Medicare provider enrollment revalidation effort does not change other aspects of the enrollment process. Providers/suppliers should continue to submit changes (for example, changes of ownership, change in practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes) as they always have. If you also receive a request for revalidation from the MAC, respond separately to that request.

- Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;
- If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:
  - Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
  - Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html
  - If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and
  - Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles in accordance with 42 CFR §424.515. This cycle of revalidation applies to those providers/suppliers that are currently and actively enrolled.

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

CMS has established due dates by which the provider/supplier's revalidation application must reach the MAC in order for them to remain in compliance with Medicare's provider enrollment requirements. The due dates will generally be on the last day of a month (for example, June 30, July 31 or August 31). Submit your revalidation application to your MAC within 6 months of your due date to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

- The list will be available at http://go.cms.gov/MedicareRevalidation and will include all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at http://go.cms.gov/MedicareRevalidation on the CMS website.
- IMPORTANT: The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.
- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.

Revalidation notices sent via email will indicate "URGENT: Medicare Provider Enrollment Revalidation Request" in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

- NOTE: Providers/suppliers who are within 2 months of their listed due dates on http://go.cms.gov/MedicareRevalidation but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.
- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large Group Coordination

Large groups (200+ members) accepting reassigned benefits from providers/suppliers identified on the CMS list will receive a letter from their MACs listing the providers linked to their group that are required to revalidate for the upcoming 6 month period. A spreadsheet detailing the applicable provider's Name, National Provider Identifier (NPI) and Specialty will also be provided. CMS encourages the groups to work with their practicing practitioners to ensure that the revalidation application is submitted prior to the due date. We encourage all groups to work together as only one application from each provider/supplier is required, but the provider must list all groups they are reassigning to on the revalidation application submitted for processing. MACs will have dedicated provider enrollment staff to assist in the large group revalidations.

Groups with less than 200 reassignments will not receive a letter or spreadsheet from their MAC, but can utilize PECOS or the CMS list available on http://go.cms.gov/MedicareRevalidation to determine their provider/supplier's revalidation due dates.

Unsolicited Revalidation Submissions

All unsolicited revalidation applications submitted more than 6 months in advance of the provider/supplier's due date will be returned.

- What is an unsolicited revalidation?
  - If you are not due for revalidation in the current 6 month period, your due date will be listed as "TBD" (To Be Determined). This means that you do not yet have a due date for revalidation. Please do not submit a revalidation application if there is NOT a listed due date.
  - Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.
- If your intention is to submit a change to your provider enrollment record, you must submit a 'change of information' application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

IMPORTANT: Each provider/supplier is required to revalidate their entire Medicare enrollment record.

A provider/supplier's enrollment record includes information such as the provider's individual practice locations and every group that benefits are reassigned (that is, the group submits claims and receives payments directly for services provided). This means the provider/supplier is recertifying and revalidating all of the information in the enrollment record, including all assigned NPIs and Provider Transaction Access Numbers (PTANs).

If you are an individual who reassigns benefits to more than one group or entity, you must include all organizations to which you reassign your benefits on one revalidation application. If you have someone else completing your revalidation application for you, encourage coordination with all entities to which you reassign benefits to ensure your reassignments remain intact.

The fastest and most efficient way to submit your revalidation information is by using the Internet-based PECOS.

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do. PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

PECOS ensures accurate and timelier processing of all types of enrollment applications, including revalidation applications. It provides a far superior alternative to the antiquated paper application process.

To locate the paper enrollment applications, refer to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html on the CMS website.

Getting Access to PECOS:

To use PECOS, you must get approved to access the system with the proper credentials which are obtained through the Identity and Access Management System, commonly referred to as "I&A". The I&A system ensures you are properly set up to submit PECOS applications. Once you have established an I&A account you can then use PECOS to submit your revalidation application as well as other enrollment application submissions.

To learn more about establishing an I&A account or to verify your ability to submit applications using PECOS, please refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

If you have questions regarding filling out your application via PECOS, please contact the MAC that sent you the revalidation notice. You may also find a list of MAC's at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/contact_list.pdf.

For questions about accessing PECOS (such as login, forgot username/password) or I&A, contact the External User Services (EUS) help desk at 1-866-484-8049 or at EUSSupport@cgi.com.

Deactivations Due to Non-Response to Revalidation or Development Requests

It is important that you submit a complete revalidation application by your requested due date and you respond to all development requests from your MACs timely. Failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

If your application is received substantially after the due date, or if you provide additional requested information substantially after the due date (including an allotted time period for US or other mail receipt) your provider enrollment record may be deactivated. Providers/suppliers deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

NOTE: The reactivation date after a period of deactivation will be based on the receipt date of the new full and complete application. Retroactive billing privileges back to the period of deactivation will not be granted. Services provided to Medicare patients during the period between deactivation and reactivation are the provider's liability.

Revalidation Timeline and Example

Providers/suppliers may use the following table /chart as a guide for the sequence of events through the revalidation progression.

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2017
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2017

MAC sends email/letter notification	75 – 90 days prior to due date	July 2 - 17, 2017
MAC sends letter for undeliverable emails	75 – 90 days prior to due date	July 2 - 17, 2017
Revalidation due date	September 30, 2017	
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2017
Deactivate	60 – 75 days after due date	November 29 – December 14, 2017

Deactivations Due to Non-Billing

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 5 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the deactivation action.

Providers/suppliers who Medicare billing privileges are deactivated will be required to submit a new full and complete application in order to reestablish their provider enrollment record and related Medicare billing privileges. The provider/supplier will maintain their original PTAN; however, an interruption in billing will occur during the period of deactivation resulting in a gap in coverage.

Application Fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $560.00 for Calendar Year (CY) 2017. CMS has defined "institutional provider" to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2017 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

Summary:

- CMS will post the revalidation due dates for the upcoming revalidation cycle on http://go.cms.gov/MedicareRevalidation for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.

- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional Information

To find out whether a provider/supplier has been mailed a revalidation notice go to http://go.cms.gov/MedicareRevalidation on the CMS website.

A sample revalidation letter is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/SampleRevalidationLetter.pdf on the CMS website. A revalidation checklist is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html on the CMS website.

For more information about the enrollment process and required fees, refer to MLN Matters® Article MM7350, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

For more information about the application fee payment process, refer to MLN Matters Article SE1130, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7350.pdf on the CMS website.

The MLN fact sheet titled "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" is designed to provide education to provider and supplier organizations on how to use Internet-based PECOS to enroll in the Medicare Program and is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf on the CMS website.

To access PECOS, your Authorized Official must register with the PECOS Identification and Authentication system. To register for the first time go to https://pecos.cms.hhs.gov/pecos/PecosIAConfirm.do?transferReason=CreateLogin to create an account.

For additional information about the enrollment process and Internet-based PECOS, please visit the Medicare Provider-Supplier Enrollment webpage at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

IVIG Demonstration Scheduled End

MLN Matters Number: SE17008

Article Release Date: May 30, 2017

Effective Date: September 30, 2017

Provider Type Affected

This MLN Matters Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) drugs and services provided to beneficiaries under the Medicare IVIG Demonstration. The article is also intended for physicians who may treat patients with primary immune deficiency syndrome that use IVIG.

Provider Action Needed

This article is a reminder of the scheduled end date for the IVIG Demonstration.

The IVIG Demonstration is a three-year demonstration that is scheduled to end September 30, 2017. Since the demonstration ends on September 30, 2017, no payment will be made for the demonstration services (Q2052- IVIG demonstration, services/supplies) rendered after that date. Claims submitted after that date for dates of service on/before September 30, 2017, will continue to be processed in accordance with the IVIG Demonstration guidelines. Please note that traditional Medicare fee for service will continue to pay for IVIG in the home but, once the demonstration ends, will no longer pay for the services and supplies to administer the drug unless the beneficiary is receiving covered Medicare home health services. Medicare

will be notifying beneficiaries enrolled in the demonstration about the ending of payment for Q2052 as the ending of the demonstration may result in beneficiaries making alternative arrangements to receive their IVIG.

Since the demonstration ends on September 30, the last date that beneficiaries can submit an application for enrollment in the demonstration is August 15, 2017. This application must be received by the IVIG Demonstration Support Contractor, Noridian, by this date either via fax or mail. Approved enrollments will be effective 9/1/17 allowing for IVIG services to be provided in the last month of the demonstration. Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration. Make sure your billing staffs are aware of the end of the demonstration.

Background

The Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 authorized a three-year demonstration under Part B of Title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the in-home administration of IVIG for the treatment of Primary Immune Deficiency Disease (PIDD).

Additional Information

For more information about the Medicare Intravenous Immune Globulin (IVIG) Demonstration, go to https://innovation.cms.gov/initiatives/ivig/. Additional information is also available on the Noridian IVIG website at https://med.noridianmedicare.com/web/ivig.

You may also want to review MLN Matters Article MM9746, which specifies the IVIG Demonstration payment rate of $354.60 for services rendered on or after January 1, 2017, through September 30, 2017, for code Q2052 (services, supplies, and accessories used in the home under the Medicare IVIG Demonstration).

Improvements to the Adjudication Process of Serial Claims

MLN Matters Number: SE17010

Article Release Date: April 26, 2017

Effective Date: April 7, 2017

Provider Type Affected

This MLN Matters® Special Edition Article is intended for Durable Medical Equipment (DME) suppliers who submit claims to DME Medicare Administrative Contractors (DME MACs) for items provided to Medicare beneficiaries.

What You Need To Know

The Centers for Medicare & Medicaid Services (CMS) is publishing this Special Edition article to inform suppliers of the Serial Claims initiative, in which CMS is implementing changes to improve the processing and adjudication of Medicare Fee-For-Service (FFS) recurring (or serial) claims for capped rental items and certain Inexpensive and Routinely Purchased (IRP) items. This initiative began in April 2017.

Background

Prior to April 2017, when one claim in a series (that is, a serial claim) was denied and then appealed independent of the other claims in the series, generally the appeal was adjudicated independently and without reference to other claims in the series. As a result, claims within a series could be denied and pending at different levels of appeal simultaneously.

As a process improvement effort, CMS recently directed the DME MACs to change the process by which they adjudicate appeals of serial claims. Once the reason for denial for one claim in a series is resolved at any appeal level, the DME MACs will identify other claims in the same series that were denied for the same or similar reasons, and take that determination into consideration when adjudicating such claims. Specifically, the DME MACs will apply this process to:

- Claims pending redeterminations; and,

- Claims in the series for which a redetermination was issued, but the timeframe to request a reconsideration by the Qualified Independent Contractor (QIC) has not yet elapsed.

The DME MACs will also communicate the favorable decision(s) to the DME QIC and the Office of Medicare Hearings and Appeals (OMHA) to consider when adjudicating related appeals pending at those levels.

CMS has also instructed the DME MACs to update the Certificate of Medical Necessity (CMN) in the ViPS Medicare System (VMS), when appropriate, to reflect when a favorable decision has been rendered for a serial claim, allowing future claims in the same series to pay without requiring suppliers to continually resubmit evidence. As a result of these changes, the Serial Claims initiative will prevent future claims that are part of a previously adjudicated series from unnecessarily entering the appeals process, since the denial reason has been resolved for a related claim in the series. This change will also ensure that items that have been subject to medical review and have been determined to meet medical necessity standards, will continue to be paid consistently for the duration of the rental period, in instances where the medical necessity decision is applicable to other claims in the series.

Finally, CMS instructed the DME MACs to perform data analysis of all favorable serial claim appeal decisions made over the past 3 years, in an effort to capture all currently pending appeals in the series that could be included in this initiative. Suppliers do not need to take any action and should not reach out to the DME MAC within their jurisdiction to request that their appeal be considered for this initiative.

Please note that the data analysis of this initiative only applies to recurring (or serial) claims for capped rental items and certain IRP items adjudicated during the 3-year timeframe. The HCPCS codes that are included in the Serial Claims initiative are attached to this article. This list is subject to change and inclusion of a claim in this initiative is at the discretion of CMS.

Additional Information

You can find out more about appealing claims decisions in the "Medicare Claims Processing Manual" (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.

Telephone Reopenings: Resources for Success

This article provides the following information on Telephone Reopenings: contact information, hours of availability, required elements, items allowed through Telephone Reopenings, those that must be submitted as a redetermination, and more.

Per the Internet-Only Manual (IOM) Publication 100-04, Chapter 34, Section 10, reopenings are separate and distinct from the appeals process. Contractors should note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Section 10.6.2 of the same Publication and Chapter states a reopening must be conducted within one year from the date of the initial determination.

How do I request a Telephone Reopening?	**To request a reopening via telephone, call 1-877-320-0390.**
What are the hours for Telephone Reopenings?	Monday through Friday 8 a.m. – 5 p.m. ET Further closing information can be found at https://med.noridianmedicare.com/web/jddme/contact/holiday-schedule.

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-877-320-0390.
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digit of Tax ID Number (TIN) • Supplier name • Beneficiary's Health Insurance Claim Number (HICN) • Beneficiary's first and last name • Beneficiary's date of birth • Date of service (DOS) • Healthcare Common Procedure Coding System (HCPCS) code(s) in question • Corrective action to be taken **Note:** Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

What may I request as a Telephone Reopening?	The following is a list of clerical errors and omissions that may be completed as a Telephone Reopening. Note: This list is not all-inclusive.
	• Diagnosis code changes or additions
	• Date of Service (DOS) changes
	• HCPCS code changes
	• Certain modifier changes or additions (not an all-inclusive list)
	  • KH
	  • KI
	  • KJ
	  • RR
	  • NU
	  • AU
	  • KL
	  • RT
	  • LT
	Note: If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-877-320-0390.

What is not accepted as a Telephone Reopening?	The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation.
	• Overutilization denials that require supporting medical records
	• Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013
	• Oxygen break in service (BIS) issues
	• Some manual wheelchairs and all power mobility devices (PMDs) – HCPCS K0005 and higher
	• Overpayments or reductions in payment
	• Medicare Secondary Payer (MSP) issues
	• Claims denied for timely filing
	• Reopenings past one year from the initial determination
	• Complex Medical Reviews or Additional Documentation Requests
	• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues
	• Repair and labor claims
	• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing
	• The following modifier changes or additions:
	  • A1 through A9
	  • K0 through K4
	  • GA
	  • GY
	  • GZ
	  • KX
	  • EY
	  • KG
	  • RA
	  • RB
	  • RP
	• Certain HCPCS codes (not all-inclusive list)
	  • A4450 through A4452
	  • E0194
	  • E0748
	  • E1028
	  • J1559
	  • J1561
	  • J1562
	  • K0108
	  • K0462

APPEALS

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-877-320-0390.
What do I do when I have a large amount of corrections?	• If a supplier has more than 50 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information and provide further direction how to submit the request • If a supplier has a least 10 DOS, the supplier can request a phone appointment for a 30 minute interval. A Telephone Reopenings representative will call the supplier at the designated time and will complete as many reopenings as possible in that time.
Where can I find more information on Telephone Reopenings?	Supplier Manual Chapter 13 Appeals Section on the Noridian DME website IOM Publication 100-04, Chapter 34
Additional assistance available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Please note, emails containing Protected Health Information (PHI) will be returned as unprocessable.

Redetermination Requests Now Accepting Electronic, Digital and/or Digitized Signatures

CMS has instructed Medicare Administrative Contractors (MACs) to begin accepting electronic, digital and/or digitized signatures on requests for an appeal. Previously, MACs were only allowed to accept handwritten or electronic signatures. This new direction means that providers may now use typed and scanned signatures on the Redetermination Form. Valid signatures must still be legible, contain at least the entire first name and may not be reduced to initials.

As required by CMS, all redetermination requests received without the appellant's signature are dismissed as incomplete requests. Noridian continues to receive numerous redetermination requests without the proper signature of the requesting party. Providers are encouraged to submit requests for redetermination via the Noridian Medicare Portal (NMP). Step-by-step instructions are available on our website. NMP is free, includes the capability to upload supporting documentation, and can speed up the appeal process.

For further information refer to the Internet Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions, Section 310.1.B.3, Requirements for a Valid Signature on an Appeal Request.

CLAIMS REVIEW

Ankle-Foot/ Knee-Ankle-Foot Orthosis (HCPCS L4361) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L4361. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

The L4361 review involved 618 claims, of which 355 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 58%.

Top Denial Reasons

- Proof of Delivery (POD) was not received.
- Claim is the same or similar to another claim on file.
- Documentation does not support coverage criteria.
- Detailed Written Order (DWO) was not received.

For complete detail see, Ankle-Foot/ Knee-Ankle-Foot Orthosis (HCPCS L4361) Quarterly Results of Service Specific Prepayment Review.

Ankle-Foot Orthosis (HCPCS L1960, L1970 and L4360) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L1960, L1970 and L4360. The quarterly edit effectiveness results from December 2016 through March 2017 are as follows:

- The L1960 review involved 204 claims, of which 136 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **66%**.
- The L1970 review involved 319 claims, of which 231 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **70%**.
- The L4360 review involved 317 claims, of which 314 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **99%**.

Top Denial Reasons

- Documentation does not support custom fit criteria.
- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.

For complete detail see, Ankle-Foot Orthosis (HCPCS L1960, L1970 and L4360) Quarterly Results of Service Specific Prepayment Review.

External Infusion Pumps (HCPCS J2260) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) J2260. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The J2260 review involved 24 claims, of which 17 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **42%.**

Top Denial Reasons

- Documentation was not received in response the Additional Documentation Request (ADR) letter.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Refill request was not received.
- Detailed Written Order (DWO) contains a length of need or number of refills which has expired.

For complete detail see, External Infusion Pumps (HCPCS J2260) Quarterly Results of Service Specific Prepayment Review.

Glucose Monitors (HCPCS A4253) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) A4253. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The A4253 review involved 425 claims, of which 404 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **92%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.
- Documentation does not support high utilization.
- An incorrect modifier was billed on the claim.

For complete detail see, Glucose Monitors (HCPCS A4253) Quarterly Results of Service Specific Prepayment Review.

Glucose Monitors (HCPCS A4253) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) A4253. The quarterly edit effectiveness results from July 2016 through October 2016 are as follows:

- The A4253 review involved 46 claims, of which 45 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **94%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter
- Documentation does not support high utilization.
- An incorrect modifier was billed on the claim.
- Medical documentation was not received.

For complete detail see, Glucose Monitors (HCPCS A4253) Quarterly Results of Service Specific Prepayment Review

Hospital Beds (HCPCS E0250) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0250. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The E0250 review involved 164 claims, of which 88 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **57%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not contain a valid date stamp or similar.
- Documentation does not support coverage criteria for a fixed height hospital bed.
- Detailed Written Order (DWO) is incomplete or missing elements.

For complete detail see, Hospital Beds (HCPCS E0250) Quarterly Results of Service Specific Prepayment Review.

Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Documentation Compliance Review

The Jurisdiction D DME MAC Medical Review Department is conducting a Documentation Compliance Review (DCR) of HCPCS code(s) J7507, J7517, J7518 and J7520. A DCR is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to the Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from October 2016 through December 2016, are as follows:

- The J7507 review involved 2,126 claims, of which 747 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 31%.
- The J7517 review involved 1,285 claims, of which 416 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 30%.
- The J7518 review involved 919 claims, of which 292 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 31%.
- The J7520 review involved 268 claims, of which 89 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 32%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is invalid or was not received.
- Detailed Written Order (DWO) was not received.
- Medical documentation was not received.

For complete detail see, Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Documentation Compliance Review.

Knee Orthosis (HCPCS L1832, L1843) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L1832 and L1843. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The L1832 review involved 139 claims, of which 137 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **99%**.
- The L1843 review involved 111 claims, of which 111 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **100%**.

For complete detail see, Knee Orthosis (HCPCS L1832, L1843) Quarterly Results of Service Specific Prepayment Review.

Knee Orthosis (HCPCS L1833) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L1833. The quarterly edit effectiveness results from December 2016 through March 2017 are as follows:

- The L1833 review involved 936 claims, of which 838 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 91%.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

- Proof of Delivery (POD) is incomplete or missing elements.
- Medical documentation was not received.

For complete detail see, Knee Orthosis (HCPCS L1833) Quarterly Results of Service Specific Prepayment Review.

Manual Wheelchairs (HCPCS K0001, K0003) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) K0001 and K0003. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The K0001 review involved 1,062 claims, of which 633 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **58%**.
- The K0003 review involved 281 claims, of which 206 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **71%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Documentation does not support coverage criteria for a lightweight wheelchair.

For complete detail see, Manual Wheelchairs (HCPCS K0001, K0003) Quarterly Results of Service Specific Prepayment Review

Nebulizer Inhalation Drugs (HCPCS J7605, J7626) Quarterly Results of Documentation Compliance Review

The Jurisdiction D DME MAC Medical Review Department is conducting a Documentation Compliance Review (DCR) of HCPCS code(s) J7605 and J7626. A DCR is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to the Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from October 2016 through December 2016, are as follows:

- The J7605 review involved 4,699 claims, of which 518 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **10%**.
- The J7626 review involved 7,134 claims, of which 1,501 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **17%**.

For complete detail see, Nebulizer Inhalation Drugs (HCPCS J7605, J7626) Quarterly Results of Documentation Compliance Review.

Nebulizer (HCPCS J7682) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) J7682. The quarterly edit effectiveness results from November 2016 through February 2017 are as follows:

- The J7682 review involved 41 claims, of which 31 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **73%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.

- Detailed Written Order (DWO) contains a length of need or number of refills which has expired.
- Proof of Delivery (POD) is incomplete or missing elements.

For complete detail see, Nebulizer (HCPCS J7682) Quarterly Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E0431) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0431. The quarterly edit effectiveness results from November 2016 through February 2017 are as follows:

- The E0431 review involved 385 claims, of which 248 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **71%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support a qualifying blood gas study.
- Detailed Written Order Prior to Delivery (WOPD) is incomplete or missing elements.

For details please see, Oxygen and Oxygen Equipment (HCPCS E0431) Quarterly Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E0434, E0439) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0434 and E0439. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The E0434 review involved 51 claims, of which 27 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **41%**.
- The E439 review involved 97 claims, of which 52 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **52%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation does not support a qualifying blood gas study.
- Detailed Written Order Prior to Delivery (WOPD) was not received.

For complete detail see, Oxygen and Oxygen Equipment (HCPCS E0434, E0439) Quarterly Results of Service Specific Prepayment Review.

Oxygen (HCPCS E1390) Final Edit Effectiveness Results of Documentation Compliance Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E1390. A Documentation Compliance Review (DCR) is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The final edit effectiveness results from September 2016 through February 2017 are as follows:

- The E1390 review involved 1,924 claims, of which 149 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **8%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Claim is a duplicate to a previously submitted claim.
- Time limit for filing a claim expired.
- Certificate of Medical Necessity (CMN) was not received.

For complete detail see, Oxygen (HCPCS E1390) Final Edit Effectiveness Results of Documentation Compliance Review.

Oxygen and Oxygen Equipment (HCPCS E1390) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E1390. The quarterly edit effectiveness results from September 2016 through December 2016 are as follows:

- The E1390 review involved 3,141 claims, of which 1,594 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **51%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation does not support a qualifying blood gas study.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Oxygen and Oxygen Equipment (HCPCS E0439 and E0434) Quarterly Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E0431) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0431. The quarterly edit effectiveness results from November 2016 through February 2017 are as follows:

- The E0431 review involved 385 claims, of which 248 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 71%.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support a qualifying blood gas study.
- Detailed Written Order Prior to Delivery (WOPD) is incomplete or missing elements.

For details please see, Oxygen and Oxygen Equipment (HCPCS E0431) Quarterly Results of Service Specific Prepayment Review.

Oxygen and Oxygen Equipment (HCPCS E1390) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E1390. The quarterly edit effectiveness results from December 2016 through March 2017 are as follows:

- The E1390 review involved 2,945 claims, of which 1,537 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **53%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation does not support a qualifying blood gas study.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical record documentation was not authenticated (handwritten or electronic) by the author.

For complete detail see, Oxygen and Oxygen Equipment (HCPCS E1390) Quarterly Results of Service Specific Prepayment Review.

Positive Airway Pressure (PAP) (HCPCS E0601KH and E0601KJ) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0601. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The E0601KH review involved 3,219 claims, of which 1,224 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **33%**.
- The E0601KJ review involved 1,769 claims, of which 744 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **47%**.

For complete detail see, Positive Airway Pressure (PAP) (HCPCS E0601KH and E0601KJ) Quarterly Results of Service Specific Prepayment Review.

Prior Authorization: Notification of Advanced Beneficiary Notice of Noncoverage (ABN) Review

Noridian Healthcare Solutions Jurisdiction D, DME MAC, Medical Review will be initiating a review of Prior Authorization (PA) applicable claims billed with a GA modifier for each of the following HCPCS code(s):

- K0856: POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
- K0861: POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

In order to evaluate compliance with Medicare coverage and coding rules, claims billed with the HCPCS codes listed above including a GA modifier for beneficiaries residing in New York are subject to this review. Suppliers billing the selected claims will receive an Additional Documentation Request (ADR) letter asking for the Advanced Beneficiary Notice of Noncoverage (ABN) to confirm that it complies with current CMS-R-131 form requirements. Submission instructions are included in the ADR.

Please fax or mail the ABN and a copy of the ADR letter to Noridian Healthcare Solutions. Failure to supply the ABN within 45 days of the date of the ADR letter will result in claim denial.

Information about ABN requirements may be found in CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 30.

Additional information, educational opportunities and training tools related to this product category are available in Education & Outreach.

Pressure Reducing Support Surfaces – Group 1 (HCPCS E0181, E0185) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0181 and E0185. The quarterly edit effectiveness results from October 2016 through February 2017 are as follows:

- The E0181 review involved 182 claims, of which 95 were denied. Based on dollars, this resulted in an

overall claim potential improper payment rate of **65%**.

- The E0185 review involved 226 claims, of which 114 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **53%**.

Top Denial Reasons

- Documentation was not received on response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Detailed Written Order Prior to Delivery (WOPD) is incomplete or missing elements.

For complete detail see, Pressure Reducing Support Surfaces – Group 1 (HCPCS E0181, E0185) Quarterly Results of Service Specific Prepayment Review.

Review Entities Beyond the DME MAC

Jurisdiction D (JD) suppliers can receive claim review requests from multiple Medicare contractors. In addition to Medical Review (MR) prepay complex reviews, suppliers billing Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for Medicare commonly encounter a variety of other review entities requesting supporting documentation and performing reviews for the Centers for Medicare & Medicaid Services (CMS). Review entities for JD may include:

Contractor	Name / Website
Program Integrity Contractor (ZPIC) Zone 2: AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	NCI, Inc.
Program Integrity Contractor (ZPIC) 1: CA, HI, NV	SafeGuardServices, LLC
Unified Program Integrity Contractor MW: IA, KS, NE, MO	NCI, Inc.
Comprehensive Error Rate Testing Contractor (CERT)	AdvanceMed
Office of Inspector General (OIG)	U.S Department of Health & Human Services
Recovery Auditor Contractor (RAC)	Performant Recovery, Inc.
Supplemental Medical Review Contractor (SMRC)	Strategic Health Solutions

To assist with identifying the many Medicare contractors and the Medicare workload for which they are responsible, please refer to the Other Review Entities listed on the Noridian webpage or view the Other Medicare Contractors DME On Demand.

Spinal Orthoses (HCPCS L0631, L0637) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L0631 and L0637. The quarterly edit effectiveness results from December 2016 through March 2017 are as follows:

- The L0631 review involved 105 claims, of which 103 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **98%**.
- The L0637 review involved 135 claims, of which 130 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **96%**.

Top Denial Reasons

- Documentation does not support custom fit criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support PDAC approval.

- Proof of Delivery (POD) was not received.

For complete detail see, Spinal Orthoses (HCPCS L0631, L0637) Quarterly Results of Service Specific Prepayment Review.

Spinal Orthosis (HCPCS L0648, L0650) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L0648 and L0650. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The L0648 review involved 383 claims, of which 279 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **74%**.
- The L0650 review involved 853 claims, of which 709 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **84%.**

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Claim is the same or similar to another claim on file.

For complete detail see, Spinal Orthosis (HCPCS L0648, L0650) Quarterly Results of Service Specific Prepayment Review.

Spinal Orthosis Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) L0450, L0452, L0454-L0458, L0460, L0462, L0464, L0466-L0470, L0472, L0480, L0482, L0484, L0486, L0488, L0490-L0492, L0621, L0623, L0625-L0643 and L0648-L0651. The quarterly edit effectiveness results from October 2016 through February 2017 are as follows:

- The TLSO review involved 29 claims, of which 28 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **97%**.
- The LSO review involved 518 claims, of which 517 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **100%**.
- The SO review involved 13 claims, of which 9 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **69%**.
- The LO review involved 120 claims, of which 120 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **100%**.

Top Denial Reasons

- Claim is the same or similar to another claim on file.
- Documentation does not support replacement criteria.
- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Spinal Orthosis Quarterly Results of Service Specific Prepayment Review.

Transcutaneous Electrical Nerve Stimulator (TENS) (HCPCS E0720) Results of Service Specific Prepayment Probe Review

- The Jurisdiction D, DME MAC, Medical Review Department completed a service specific prepayment probe review of HCPCS code E0720. This review was initiated based on data analysis.
- The E0720 review involved 112 claims, of which 107 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **95%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not demonstrate re-evaluation at the end of the trial period. TENS usage for chronic low back pain does not require a trial period or re-evaluation.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation does not demonstrate chronic, intractable pain other than chronic low back pain.

For complete detail see, Transcutaneous Electrical Nerve Stimulator (TENS) (HCPCS E0720) Results of Service Specific Prepayment Probe Review.

Transcutaneous Electrical Nerve Stimulator (TENS) (HCPCS E0730) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0730. The quarterly edit effectiveness results from November 2016 through February 2017 are as follows:

- The E0730 review involved 18 claims, of which 17 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **94%**.

Top Denial Reasons

- Documentation does not demonstrate re-evaluation at the end of the trial period.
- TENS usage for chronic low back pain does not require a trial period or re-evaluation.
- Documentation does not demonstrate chronic, intractable pain other than chronic low back pain.
- Documentation does not support the item billed.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Transcutaneous Electrical Nerve Stimulator (TENS) (HCPCS E0730) Quarterly Results of Service Specific Prepayment Review.

Therapeutic Shoes (HCPCS A5500) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) A5500. The quarterly edit effectiveness results from December 2016 through March 2017 are as follows:

- The A5500 review involved 2,510 claims, of which 1,767 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **70%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Medical documentation was not received.
- Documentation received is illegible.

For complete detail see, Therapeutic Shoes (HCPCS A5500) Quarterly Results of Service Specific Prepayment Review.

Urological Supplies (HCPCS A4351, A4353, A4358) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) A4351, A4353 and A4358. The quarterly edit effectiveness results from October 2016 through January 2017 are as follows:

- The A4351 review involved 1,508 claims, of which 822 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **51%**.
- The A4353 review involved 222 claims, of which 172 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **76%**.
- The A4358 review involved 1,378 claims, of which 945 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **70%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.
- Documentation does not support coverage criteria.
- Refill request was not received.

For complete detail see, Urological Supplies (HCPCS A4351, A4353, A4358) Quarterly Results of Service Specific Prepayment Review.

Performant Receives CMS Approval to Begin Audit Activities

Performant, the Region 5 National Recovery Audit Contractor (RAC) for Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS), Home Health & Hospice services has received approval from CMS to begin recovery audit activity for DMEPOS Suppliers. Suppliers may visit the Performant Provider Portal website to view CMS approved issues list, access FAQs, forms and sample documents. Also, ensure that your provider contact information is current. For questions, contact Performant Customer Service at 866-201-0580 Monday through Friday 8 a.m. - 4:30 p.m. Eastern Time or by email at info@performanctrac.com.

Tips for Submitting ADR Responses

To ensure prompt and accurate processing of faxed documentation, Noridian encourages suppliers to follow a few basic tips when responding to Additional Documentation Requests (ADR).

Responding via fax:

- **Adjust the fax machine settings to ensure highest resolution of scanned images**
  Configure the settings on the fax machine being used to the highest resolution for optimal results. This will ensure that the barcode on the ADR letter will be read accurately within Noridian systems when the documentation is faxed in. The process of how to change settings will depend upon the type of fax machine the supplier uses; however, Noridian suggests changing the resolution of the faxes to "Fine" or higher if the machine allows.
- **Submit the original ADR letter as the first page of each fax submission.**
  Including the original ADR letter as the first page of a supplier's claim submission followed by any required medical records or documentation will ensure the barcode listed on the ADR can electronically align the documentation and the corresponding claim. The use of a fax coversheet may impair the

scanners' ability to read the barcode.

- **Ensure the document being faxed is clear and legible.**
  Avoid any handwritten notes on the ADR letters.
- **Submit each ADR response to the fax number listed on the ADR letter.**
  When faxed responses are sent to an incorrect department, the processing and/or response time will increase.

Responding via all media:

- **Submit each individual ADR response separately.**
  When multiple responses are combined into a single response, the likelihood of a delay in processing increases.
- **Avoid submitting duplicate responses.**
  Sending duplicate responses will increase the processing and/or response time.
- **Include all documents needed for an ADR response in a single submission.**
  Avoid submitting multiple submissions for one ADR response to avoid processing delays.

Additional information and resources regarding other important Medicare topics are located in the DME MAC Jurisdiction D Supplier Manual. If you need additional assistance, please contact our Supplier Contact Center at 877-320-0390.

QMB Indicator in the Medicare Fee-For-Service Claims Processing System – Revised

MLN Matters® Number: MM9911 Revised

Related Change Request (CR) #: CR 9911

Related CR Release Date: April 28, 2017

Effective Date: For claims processed on or after October 2, 2017

Related CR Transmittal #: R3764CP

Implementation Date: October 2, 2017

The article was revised on May 1, 2017, to reflect a revised CR9911 issued on April 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9911 modifies the Medicare claims processing systems to help providers more readily identify the Qualified Medicare Beneficiary (QMB) status of each patient and to support providers' ability to follow QMB billing requirements. Beneficiaries enrolled in the QMB program are not liable to pay Medicare cost-sharing for all Medicare A/B claims. CR 9911 adds an indicator of QMB status to Medicare's claims processing systems. This system enhancement will trigger notifications to providers (through the Provider Remittance Advice) and to beneficiaries (through the Medicare Summary Notice) to reflect that the beneficiary is enrolled in the QMB program and has no Medicare cost-sharing liability. Make sure that your billing staffs are aware of these changes.

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-

sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Under federal law, Medicare providers may not bill individuals enrolled in the QMB program for Medicare deductibles, coinsurance, or copayments, under any circumstances. (See Sections 1902(n)(3)(B); 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.) State Medicaid programs may pay providers for Medicare deductibles, coinsurance, and copayments. However, as permitted by Federal law, states can limit provider reimbursement for Medicare cost-sharing under certain circumstances. Nonetheless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to an individual enrolled in the QMB program.

CR 9911 aims to support Medicare providers' ability to meet these requirements by modifying the Medicare claims processing system to clearly identify the QMB status of all Medicare patients. Currently, neither the Medicare eligibility systems (the HIPAA Eligibility Transaction System (HETS)), nor the claims processing systems (the FFS Shared Systems), notify providers about their patient's QMB status and lack of Medicare cost-sharing liability. Similarly, Medicare Summary Notices (MSNs) do not inform those enrolled in the QMB program that they do not owe Medicare cost-sharing for covered medical items and services.

CR 9911 includes modifications to the FFS claims processing systems and the "Medicare Claims Processing Manual" to generate notifications to Medicare providers and beneficiaries regarding beneficiary QMB status and lack of liability for cost-sharing.

With the implementation of CR 9911, Medicare's Common Working File (CWF) will obtain QMB indicators so the claims processing systems will have access to this information.

- CWF will provide the claims processing systems the QMB indicators if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional Types of Bill (TOB) 012x, 013x, 014x, 022x, 023x, 034x, 071x, 072x, 074x, 075x, 076x, 077x, and 085x); home health claims (TOB 032x) only if the revenue code for the line item is 0274, 029x, or 060x; and Skilled Nursing Facility (SNF) claims (based on occurrence code 50 date for revenue code 0022 lines on TOBs 018x and 021x).
- CWF will provide the claims processing systems the QMB indicator if the "through date" falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims (TOB 011x) and religious non-medical health care institution claims (TOB 041x).

The QMB indicators will initiate new messages on the Remittance Advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with three new Remittance Advice Remark Codes (RARC) that are specific to those enrolled in QMB. As appropriate, one or more of the following new codes will be returned:

- N781 – No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N782 – No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.
- N783 – No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance, deductible or co-payments.

In addition, the MACs will include a Claim Adjustment Reason Code of 209 ("Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA (Other Adjustment)).

Finally, CR 9911 will modify the MSN to inform beneficiaries if they are enrolled in QMB and cannot be billed for Medicare cost-sharing for covered items and services.

Additional Information

The official instruction, CR 9911, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3764CP.pdf.

For more information regarding billing rules applicable to individuals enrolled in the QMB Program, see

the MLN Matters article, SE1128, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

Improvements to the Adjudication Process of Serial Claims

MLN Matters Number: SE17010
Article Release Date: April 26, 2017
Effective Date: April 7, 2017

Provider Type Affected

This MLN Matters® Special Edition Article is intended for Durable Medical Equipment (DME) suppliers who submit claims to DME Medicare Administrative Contractors (DME MACs) for items provided to Medicare beneficiaries.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is publishing this Special Edition article to inform suppliers of the Serial Claims initiative, in which CMS is implementing changes to improve the processing and adjudication of Medicare Fee-For-Service (FFS) recurring (or serial) claims for capped rental items and certain Inexpensive and Routinely Purchased (IRP) items. This initiative began in April 2017.

Background

Prior to April 2017, when one claim in a series (that is, a serial claim) was denied and then appealed independent of the other claims in the series, generally the appeal was adjudicated independently and without reference to other claims in the series. As a result, claims within a series could be denied and pending at different levels of appeal simultaneously.

As a process improvement effort, CMS recently directed the DME MACs to change the process by which they adjudicate appeals of serial claims. Once the reason for denial for one claim in a series is resolved at any appeal level, the DME MACs will identify other claims in the same series that were denied for the same or similar reasons, and take that determination into consideration when adjudicating such claims. Specifically, the DME MACs will apply this process to:

- Claims pending redeterminations; and,
- Claims in the series for which a redetermination was issued, but the timeframe to request a reconsideration by the Qualified Independent Contractor (QIC) has not yet elapsed.

The DME MACs will also communicate the favorable decision(s) to the DME QIC and the Office of Medicare Hearings and Appeals (OMHA) to consider when adjudicating related appeals pending at those levels.

CMS has also instructed the DME MACs to update the Certificate of Medical Necessity (CMN) in the ViPS Medicare System (VMS), when appropriate, to reflect when a favorable decision has been rendered for a serial claim, allowing future claims in the same series to pay without requiring suppliers to continually resubmit evidence. As a result of these changes, the Serial Claims initiative will prevent future claims that are part of a previously adjudicated series from unnecessarily entering the appeals process, since the denial reason has been resolved for a related claim in the series. This change will also ensure that items that have been subject to medical review and have been determined to meet medical necessity standards, will continue to be paid consistently for the duration of the rental period, in instances where the medical necessity decision is applicable to other claims in the series.

Finally, CMS instructed the DME MACs to perform data analysis of all favorable serial claim appeal decisions made over the past 3 years, in an effort to capture all currently pending appeals in the series that could be included in this initiative. Suppliers do not need to take any action and should not reach out to the DME MAC within their jurisdiction to request that their appeal be considered for this initiative.

Please note that the data analysis of this initiative only applies to recurring (or serial) claims for capped rental items and certain IRP items adjudicated during the 3-year timeframe. The HCPCS codes that are included in the Serial Claims initiative are attached to this article. This list is subject to change and inclusion of a claim in this initiative is at the discretion of CMS.

Additional Information

You can find out more about appealing claims decisions in the "Medicare Claims Processing Manual" (Publication 100-04, Chapter 29 (Appeals of Claims Decisions), at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf.

Policy Specific Requirements for Enteral Nutrition Detailed Written Orders

Many DMEPOS policies have requirements that are specific to that policy and are necessary for orders or other documentation. A Detailed Written Order (DWO) for enteral nutrition must include the Route of Administration (ROA) as well as the Method of Administration (MOA).

Route of Administration would be whether the beneficiary receives the nutrition through an NG tube, G tube, or J tube.

Method of Administration is also necessary to be on the DWO and would be how the nutrition is delivered. Medicare covers the three following MOAs for Enteral Nutrition:

- Syringe (B4034)
- Gravity (B4036)
- Pump (B4035)

Refer to the LCD and Policy Article for the DMEPOS item to determine if there are any special documentation requirements for items you supply.

More information on the Enteral Nutrition Policy can be found in the Enteral Nutrition LCD and Policy Article.

Two New K Codes for Therapeutic Continuous Glucose Monitors – Revised

MLN Matters Number: MM10013 Revised

Related Change Request (CR) Number: 10013

Related CR Release Date: May 18, 2017

Effective Date: July 1, 2017

Related CR Transmittal Number: R3775CP

Implementation Date: July 3, 2017

This article was revised on May 18, 2017, to reflect the revised CR10013 issued on May 18. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Action Needed

This MLN Matters Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 10013 provides the two codes for therapeutic Continuous Glucose Monitors (CGM) that will be added to the Healthcare Common Procedure Coding System (HCPCS) code set, effective July 1, 2017. The addition of these codes (K0553 and K0554) will facilitate Durable Medical Equipment (DME) MAC claims processing for therapeutic CGMs. Make sure that your billing staffs are aware of these two new codes.

ENTERAL NUTRITION

Background

On January 12, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a Ruling (CMS-1682-R), concluding that certain CGM, referred to as therapeutic CGMs, are considered durable medical equipment (DME).

Continuous glucose monitoring systems are considered therapeutic CGMs (and therefore DME), if the equipment:

- Is approved by the Food and Drug Administration for use in place of a blood glucose monitor for making diabetes treatment decisions (for example, changes in diet and insulin dosage)
- Is generally not useful to the individual in the absence of an illness or injury
- Is appropriate for use in the home
- Includes a durable component (a component that CMS determines can withstand repeated use and has an expected lifetime of at least 3 years) that is capable of displaying the trending of the continuous glucose measurements

To facilitate implementation of this Ruling, the following two codes will be added to the HCPCS code set effective July 1, 2017:

- K0553 Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 unit of service = 1 month's supply
- K0554 Receiver (Monitor), dedicated, for use with therapeutic continuous glucose monitor system.

The billing jurisdiction for both of these codes will be the DME MAC.

Additional Information

CMS 1682-R at https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1682R.pdf.

The official instruction, CR 10013, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3775CP.pdf.

LCD AND POLICY ARTICLES

Billing Instructions - Continuous Glucose Monitors

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Billing Instructions – Continuous Glucose Monitors" is now available on our (Noridian) website.

View the complete Billing Instructions – Continuous Glucose Monitors webpage.

Coding and Coverage - Therapeutic Continuous Glucose Monitors (CGM)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Coding and Coverage – Therapeutic Continuous Glucose Monitors (CGM)" is now available on our (Noridian) website.

View the complete Coding and Coverage – Therapeutic Continuous Glucose Monitors (CGM) webpage.

Continuous Glucose Monitors - Frequently Asked Questions

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Continuous Glucose Monitors – Frequently Asked Questions" is now available on our (Noridian) website.

View the complete Continuous Glucose Monitors – Frequently Asked Questions webpage.

Correct Coding and Coverage - Braces Constructed Primarily of Elastic or Other Fabric Materials - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding and Coverage – Braces Constructed Primarily of Elastic or Other Fabric Materials - Revised" has been updated.

Summary of changes:

Revision History

Publication Date: March 16, 2017

- Deleted HCPCS Code A4466
- Added A4467
- Revised narrative consistent with code changes and added coding scenarios.

Publication Date: July 28, 2016

- Revised PDAC Article "Elastic Garments – Noncovered" to provide a more comprehensive discussion of statutory benefit category requirements and HCPCS coding guidelines applicable to these items.

Original Publication Date: January 1, 2009

View the complete Correct Coding and Coverage – Braces Constructed Primarily of Elastic or Other Fabric Materials - Revised webpage.

Correct Coding - Interferential Current (IFC) Therapy Devices

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Interferential Current (IFC) Therapy Devices" is now available on our (Noridian) website.

View the complete Correct Coding – Interferential Current (IFC) Therapy Devices webpage.

DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps - Revised" has been updated.

Summary of changes:

Publication Date: April 2017

Revised: Clarifies that a Revised DIF instead of a Recertification DIF is required for Parenteral and Enteral Nutrition when the ordering physician extends length of need.

Deleted: HCPCS Code B9000, which was cross walked to HCPCS Code B9002

View the complete DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps - Revised webpage.

DMD Articles Accessible from the Medical Director Articles Webpage

Have you visited the Medical Director Articles webpage? The "Medical Director Articles" webpage, located within the "Policies" section of our website is the place to get the most up to date clarification written by the DME Medical Directors (DMD) from both DME MACs.

The various articles provide clarification on local coverage determinations (LCD), coding, medical review, related billing and claims considerations. Articles also may include new educational materials, coding instructions or clarification of existing medical review related billing or claims policy. Some examples of the most recently posted articles include billing instructions for Continuous Glucose Monitors (CGM), LCD and

policy article revisions, DME Information Form (DIF) usage for infusion pumps and a reminder about the Dear Physician Letter.

Watch for this webpage to grow as previous years and present articles continue to be added.

View the Medical Director Articles webpage.

Glucose Monitors LCD and Related Policy Article – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Glucose Monitors LCD and Related Policy Article – Revised" is now available on our (Noridian) website.

View the complete Glucose Monitors LCD and Related Policy Article – Revised webpage.

Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Items Provided on a Recurring Basis and Request for Refill Requirements – Annual Reminder" is now available on our (Noridian) website.

View the complete Items Provided on a Recurring Basis and Request for Refill Requirements – Annual Reminder webpage.

LCD and Policy Article Revisions Summary for March 16, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for March 16, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for March 16, 2017 webpage.

LCD and Policy Article Revisions Summary for March 23, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for March 23, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for March 23, 2017 webpage.

LCD and Policy Article Revisions Summary for March 30, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for March 30, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for March 30, 2017 webpage.

LCD and Policy Article Revisions Summary for April 6, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for April 6, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for April 6, 2017 webpage.

LCD and Policy Article Revisions Summary for April 20, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for April 20, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for April 20, 2017 webpage.

LCD and Policy Article Revisions Summary for April 27, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for April 27, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for April 27, 2017 webpage.

LCD and Policy Article Revisions Summary for May 4, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for May 4, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for May 4, 2017 webpage.

LCD and Policy Article Revisions Summary for May 11, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for May 11, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for May 11, 2017 webpage.

LCD and Policy Article Revisions Summary for May 18, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for May 18, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for May 18, 2017 webpage.

LCD and Policy Article Revisions Summary for May 25, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for May 25, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for May 25, 2017 webpage.

Policy Article Revisions Summary for June 1, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revisions Summary for June 1, 2017" is now available on our (Noridian) website.

View the complete Policy Article Revisions Summary for June 1, 2017 webpage.

Reminder – Oxygen Qualification Tests and Documentation

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Reminder – Oxygen Qualification Tests and Documentation" is now available on our (Noridian) website.

View the complete Reminder – Oxygen Qualification Tests and Documentation webpage.

Standard Documentation Requirements for All Claims Submitted to DME MACs

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)" is now available on our (Noridian) website.

View the complete Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) webpage.

MLN Connects – March 2, 2017

MLN Connects® for Thursday, March 2, 2017

View this edition as a PDF

News & Announcements

- IRF and LTCH QRP Preview Reports Available: Review by March 30
- March is National Colorectal Cancer Awareness Month

Provider Compliance

- Home Health Care: Proper Certification Required

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Home Health Quality Reporting Program Provider Training — May 3 and 4

Medicare Learning Network Publications & Multimedia

- Critical Access Hospital Booklet — Revised
- Transitional Care Management Services Fact Sheet — Revised
- MREP Software Fact Sheet — Reminder
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet — Reminder
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder

MLN Connects – March 9, 2017

MLN Connects® for Thursday, March 9, 2017

View this edition as a PDF

News & Announcements

- Social Security Number Removal Initiative: New Details
- Clinical Laboratories: Report Lab Data through March 31
- New Release of PEPPER for Short-term Acute Care Hospitals
- Hospice Quality Reporting Program: Rerun Your Quality Measure Reports
- LTCHs: Exceptions to Moratorium on Increasing Beds
- Therapeutic Continuous Glucose Monitors Classified as Durable Medical Equipment
- Influenza Activity Continues: Are Your Patients Protected?

Provider Compliance

- Chiropractic Services: High Improper Payment Rate within Medicare FFS Part B

Claims, Pricers & Codes

- April 2017 Average Sales Price Files Available

Upcoming Events

- SNF VBP: Understanding Your Facility's Confidential Feedback Report Call — March 15
- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Medicare Diabetes Prevention Program Expanded Model Webinar — March 22
- Medicare ACO Track 1+ Model Webinar — March 22

- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Open Payments: Prepare to Review Reported Data Call — April 13

Medicare Learning Network Publications & Multimedia

- Medicare Enrollment Resources Educational Tool — New
- Chronic Care Management Services Call: Audio Recording and Transcript — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Suite of Products & Resources Educational Tools — Revised
- Federally Qualified Health Center Fact Sheet — Revised
- PECOS for DMEPOS Suppliers Fact Sheet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Reminder
- Advance Care Planning Fact Sheet — Reminder

MLN Connects – March 16, 2017

MLN Connects® for Thursday, March 16, 2017

View this edition as a PDF

News & Announcements

- Revised CMS-855O Application: Enrollment Solely to Order, Certify, or Prescribe
- Comparative Billing Report on Sudomotor Function Testing in April
- IRF and LTCH QRP Preview Reports Available: Review by March 30
- Improve Health during National Nutrition Month®

Provider Compliance

- Inpatient Skilled Nursing Facility Denials

Claims, Pricers & Codes

- Chronic Care Management Payment Correction for RHCs and FQHCs

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — March 21
- Medicare ACO Track 1+ Model Webinar — March 22
- DMEPOS Adjusted Fee Methodology for Non-Bid Areas: Stakeholder Input on Section 16008 of the 21st Century Cures Act Call — March 23
- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6
- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Comparative Billing Report Webinar on Sudomotor-Function Testing — May 10

Medicare Learning Network Publications & Multimedia

- Rural Health Clinic Fact Sheet — Revised

MLN Connects – March 23, 2017

MLN Connects® for Thursday, March 23, 2017

View this edition as a PDF

News & Announcements

- Connected Care: New Educational Initiative to Raise Awareness of Chronic Care Management
- Quality Payment Program: New Materials
- IRF and LTCH Compare Quarterly Refresh

Provider Compliance

- Preventive Services CMS Provider Minute Video

Upcoming Events

- IMPACT Act: Standardized Patient Assessment Data Activities Call — March 29
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6
- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19

Medicare Learning Network Publications & Multimedia

- Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article — Revised
- Medicare-Required SNF PPS Assessments Educational Tool — Revised
- Items and Services Not Covered under Medicare Booklet — Revised

MLN Connects – March 30, 2017

MLN Connects® for Thursday, March 30, 2017

View this edition as a PDF

News & Announcements

- MIPS Annual Call for Measures and Activities through June 30
- CMS Voluntary Self-Referral Disclosure Protocol: New Form
- Provider Compliance
- Billing For Stem Cell Transplants

Upcoming Events

- MIPS Cost Measure Development Listening Session — April 5
- Medicare Shared Savings Program ACO: Preparing to Apply for the 2018 Program Year Call — April 6
- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27

Medicare Learning Network Publications & Multimedia

- NPI: What You Need to Know Booklet — New
- IRF-PAI Call: Video Presentation — New
- ESRD QIP Call: Follow-up Questions and Answers — New

- SNF Consolidated Billing Web-Based Training Course — Revised
- Remittance Advice Resources and FAQs Fact Sheet — Revised
- Reading a Professional Remittance Advice Booklet— Revised
- Medicare Home Health Benefit Booklet — Revised
- MLN Learning Management System FAQs Booklet — Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Booklet — Reminder
- Medicare Enrollment for Institutional Providers Booklet — Reminder
- Safeguard Your Identity and Privacy Using PECOS Booklet — Reminder

MLN Connects – April 6, 2017

MLN Connects® for Thursday, April 6, 2017

View this edition as a PDF

News & Announcements

- Clinical Laboratory Data Reporting: Enforcement Discretion
- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- MIPS Group Web Interface and CAHPS Reporting: Registration Period Open through June 30
- Home Health and LTCH Quality Reporting Program Review and Correct Reports Available
- 2018 Medicare Shared Savings Program: Notice of Intent to Apply Guidance Document Available
- April Quarterly Provider Update Available
- Help Prevent Alcohol Misuse or Abuse

Provider Compliance

- Lumbar Spinal Fusion CMS Provider Minute Video

Claims, Pricers & Codes

- Home Health Services Pre-Claim Review Demonstration Pause

Upcoming Events

- Open Payments: Prepare to Review Reported Data Call — April 13
- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- Hospice Quality Reporting Program: Public Reporting Webinar — April 27

Medicare Learning Network Publications & Multimedia

- Denial of Home Health Payments When Required Patient Assessment Is Not Received: Additional Information MLN Matters® Article — New
- SNF Value-Based Purchasing Call: Audio Recording and Transcript — New
- Dementia Care Call: Audio Recording and Transcript — New
- Reading an Institutional RA Booklet — Revised
- PECOS for Physicians and Non-Physician Practitioners Booklet — Reminder

MLN Connects – April 13, 2017

MLN Connects® for Thursday, April 13, 2017

View this edition as a PDF

News & Announcements

- Accountable Health Communities Model: CMS Selects 32 Participants
- Mapping Medicare Disparities Tool: Identify Disparities in Chronic Disease
- Questions about Medicare Enrollment Revalidation?
- Administrative Simplification: New Fact Sheet and Infographic
- National Healthcare Decisions Day is April 16

Provider Compliance

- Billing for Ambulance Transports

Claims, Pricers & Codes

- April 2017 OPPS Pricer File

Upcoming Events

- Medicare Shared Savings Program ACO: Completing the 2018 Application Process Call — April 19
- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network Publications & Multimedia

- April 2017 Catalog Available
- Quality Payment Program in 2017: Pick Your Pace Web-Based Training Course — New
- 2017 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — New
- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 3] Educational Tool — New
- IMPACT Act Call: Audio Recording and Transcript — New
- Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article — Revised
- Home Health Prospective Payment System Booklet — Revised

MLN Connects – April 20, 2017

MLN Connects® for Thursday, April 20, 2017

View this edition as a PDF

News & Announcements

- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply May 1 through 31
- IRF/LTCH/SNF QRP Data Due May 15
- Rural Community Hospital Demonstration: Submit Applications by May 17
- New Quality Payment Program Resources Available
- Revised CMS-588: Electronic Funds Transfer Authorization Agreement
- SNF QRP Quick Reference Guide Now Available
- Beneficiary Notice Initiative: New Email Address for Questions

- April is National Minority Health Month

Provider Compliance

- Psychiatry and Psychotherapy CMS Provider Minute Video

Upcoming Events

- Global Surgery: Required Data Reporting for Post-Operative Care Call — April 25
- Emergency Preparedness Requirements Final Rule Training Call — April 27
- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2

Medicare Learning Network Publications & Multimedia

- Medicare Shared Savings Program Call: Audio Recording and Transcript — New
- Provider Compliance Products Fact Sheet — Revised
- Provider Compliance Tips for Spinal Orthoses Fact Sheet — Revised
- SNF Billing Reference Booklet — Revised

MLN Connects – April 27, 2017

MLN Connects® for Thursday, April 27, 2017

View this edition as a PDF

News & Announcements

- Clinicians: MIPS Participation Status Letter
- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- EHR Incentive Programs: Submit Comments on Proposed Changes by June 13
- IMPACT Act Data Elements Public Comments Due June 26
- IRF Quality Reporting Program Review and Correct Reports Available
- Quality Payment Program: New Videos for Small, Rural, and Underserved Practices
- EHR Incentive Programs: Public Health Agency and Clinical Data Registry Reporting
- Updated Advance Beneficiary Notice
- Antipsychotic Drug use in Nursing Homes: Trend Update
- April is STD Awareness Month: Talk, Test, Treat

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Upcoming Events

- IRF, LTCH, SNF QRP Review and Correct Reports Provider Training Webcast — May 2
- Comparative Billing Report on Transitional Care Management Webinar — June 21

Claims, Pricers & Codes

- Hospitals and SNFs: Claims Hold Related to VA Claims

Medicare Learning Network Publications & Multimedia

- Next Generation ACO – All Inclusive Population Based Payment Implementation MLN Matters Article — New
- Open Payments Call: Audio Recording and Transcript — New
- Medicare Home Health Benefit Web-Based Training Course — Revised

- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised
- Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet — Revised
- PECOS FAQs Booklet — Reminder

MLN Connects – May 4, 2017

MLN Connects® for Thursday, May 4, 2017

View this edition as a PDF

News & Announcements

- DMEPOS Revised Blended Fee Schedule Amounts
- TEP on SNF QRP Development and Maintenance of Quality Measures: Nominations due May 12
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- MIPS: Submit Measures for the Advancing Care Information Performance Category by June 30
- Hospice Item Set V2.00.0 Receives OMB Approval
- EHR Incentive Programs: Review 2017 Program Requirements
- Hand Hygiene Day is May 5

Provider Compliance

- Cochlear Devices Replaced Without Cost: Bill Correctly

Upcoming Events

- MIPS Group Reporting 101 Webinar — May 11
- Medicare Learning Network Publications & Multimedia
- Medicare Shared Savings Program Call: Audio Recording and Transcript — New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Revised
- Medicare Ambulance Transports Booklet — Revised
- Looking for the Latest National Medicare Policy Information?

MLN Connects – May 11, 2017

MLN Connects® for Thursday May 11, 2017

View this edition as a PDF

News & Announcements

- Open Payments Program Year 2016 Review and Dispute Period Ends May 15
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- Lookup Tool to Help Determine MIPS Participation Status
- Updated CY 2018 eCQM Specifications Available
- New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs
- Requesting Appeal Redeterminations
- National Women's Health Week Kicks off on Mother's Day

Provider Compliance

- CMS Provider Minute Video: Coudé Tip Catheters

Medicare Learning Network Publications & Multimedia

- Global Surgery Call: Audio Recording and Transcript — New
- Emergency Preparedness Call: Audio Recording and Transcript — New
- Resources for Medicare Beneficiaries Booklet — Revised
- SNF Billing Reference Booklet — Revised
- Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised

MLN Connects – May 18, 2017

MLN Connects® for Thursday, May 18, 2017

View this edition as a PDF

News & Announcements

- Clinical Laboratories: Lab Data Due May 30
- SNF Quality Reporting Program: Submission Deadline Extended to June 1
- National Mental Health Awareness Month 2017

Provider Compliance

- Reporting Changes in Ownership

Claims, Pricers & Codes

- 2018 ICD-10-PCS Files Available

Upcoming Events

- Quality Payment Program Participation Criteria Webinar — May 22
- National Partnership to Improve Dementia Care and QAPI Call — June 15

Medicare Learning Network Publications & Multimedia

- Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership MLN Matters Article — New
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training Course — Reminder

MLN Connects – May 25, 2017

MLN Connects® for Thursday, May 25, 2017

View this edition as a PDF

News & Announcements

- Social Security Number Removal Initiative Reminder: Get Your Systems Ready
- 2018 Medicare Shared Savings Program: Submit Notice of Intent to Apply by May 31
- Quality Payment Program: Technical Assistance Resource Guide Available
- SNF QRP Quality Measure User's Manual
- Administrative Simplification: Get the Basics
- May is National Osteoporosis Month

Provider Compliance

- Advanced Life Support Ambulance Services: Insufficient Documentation

MLN CONNECTS

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- CBR on Anesthesia Services for Lower Endoscopic Procedures Webinar — July 12

Medicare Learning Network Publications & Multimedia

- ABCs of the Initial Preventive Physical Examination Educational Tool — Revised

NORIDIAN MEDICARE PORTAL

Self-Service Reopenings Through Noridian Medicare Portal – More Options Available!

Noridian has expanded the Self Service Reopening options in the portal! This functionality allows real-time adjustments for claim corrections. Simply select Self Service Reopening under Related Inquiries after the claim you would like to correct has been selected. This will take you through the four-step process and provide a confirmation number associated to the new claim.

The following types of reopenings can now be made:

- Add, replace or remove diagnosis codes
- Add or replace modifiers
- Reprocess a claim
- Update submitted billed amount
- Update procedure code and billed amount
- Update procedure code, modifier, and billed amount
- Update units and billed amount
- Update units, modifier, and billed amount
- Update date of service
- Updated place of service (can only be changed to 12 for DMEPOS)

Reopenings are available for claims that meet the following criteria:

- No adjustment has been previously made on claim
- No redetermination has been made on claim
- Claim has not been under review
- Claim is not unprocessable (MA130 remark code)
- Reason for denial is not too complex and documentation is not needed
- Claim is not paid
- Claim was processed within one year
- Claim is finalized

After the reopening has been submitted, End Users may view the adjustment through the Claim Status option.

See the User Manual and self-paced tutorial for step-by-step instructions.

For assistance with this function, call the Contact Center at 877-320-0390.

Multi-Factor Authentication Required on Noridian Medicare Portal - Beginning April 1, 2017

Beginning April 1, 2017, the Noridian Medicare Portal (NMP) will require a multi-factor authentication (MFA) process for new users each time you log in. MFA adds a second layer of security to your NMP account. The MFA process issues a one-time passcode that will be delivered to you via email, voice phone call or text message (SMS). By adding this additional security feature, your NMP account will remain secure even if your password is obtained by someone else without your knowledge.

Due to the nature of the information obtained in NMP, the Centers of Medicare and Medicaid Services (CMS) has informed all Medicare Administrative Contractors (MACs) that this feature is mandatory. Noridian is taking a "phased" approach which will ensure all NMP users are in compliance before the September 30, 2017 deadline.

Users will be required to provide up to two additional methods, or factors, for authentication when accessing NMP. The first method is the email address that is currently on your NMP account. The additional delivery methods available are voice phone call and text message (SMS). Noridian requires at least two methods to provide a backup delivery method if you are not able to use your primary or default method. After enrollment in MFA has been completed, each time you log into the portal, you will need to provide your Username, password and the one-time passcode received via email, voice phone call or text message.

When this change will affect you:

New users registering on or after April 1, 2017:

For new users registering for an NMP account on or after April 1, 2017, enrolling in MFA will no longer be an option, but part of the normal registration process. You will be prompted to set up your MFA verifications, and each time you log in you will be sent a one-time passcode to use.

Current NMP users:

If you are a current NMP user, you can continue to log in as per usual. **As part of our "phased" approach, you will receive an email one week in advance, informing you of the date you will be required to use MFA with each login.** On the date noted in that email, NMP will prompt you to set up your MFA verifications and each time you log in you will be sent a one-time passcode to use.

Additional information and instructions are provided on the Noridian Medicare Portal page of your Jurisdictions Noridian website. Users may also contact **Noridian User Security** at the below phone numbers.

- Jurisdiction A: 866-419-9458
- Jurisdiction D: 877-320-0390
- Jurisdiction E: 855-609-9960
- Jurisdiction F: 877-908-8431

Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment – Revised

MLN Matters® Number: MM9848 Revised

Related Change Request (CR) #: CR 9848

Related CR Release Date: March 3, 2017

Effective Date: April 1, 2017

Related CR Transmittal #: R3730CP

Implementation Date: April 3, 2017

This article was revised on March 6, 2017, to reflect the release of an updated Change Request (CR). That update added an instruction for the MACs. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen services provided to Medicare beneficiaries.

Provider Action Needed

CR 9848 updates Chapter 20, Section 130.6 of the "Medicare Claims Processing Manual" to provide additional instructions in processing claims for oxygen and oxygen equipment. Make sure that your billing staffs are aware of these changes.

Key Points of CR9848

The fee schedule amount for stationary oxygen equipment is increased under the following conditions. If both conditions apply, DME MACs use the higher of either of the following add-ons, but may not pay both add-ons:

Volume Adjustment

If the prescribed amount of oxygen for stationary equipment exceeds 4 liters per minute, the fee schedule amount for stationary oxygen rental is increased by 50 percent. If the prescribed liter flow for stationary oxygen is different than for portable or different for rest and exercise, DME MACs use the prescribed amount for stationary systems and for patients at rest. If the prescribed liter flow is different for day and night use, DME MACs use the average of the two rates.

Portable Add-on

If portable oxygen is prescribed, the fee schedule amount for portable equipment is added to the fee schedule amount for stationary oxygen rental.

The following HCPCS code modifiers should be used to denote when the oxygen flow exceeds 4 liters per minute:

- QF - Prescribed amount of oxygen is greater than 4 Liter Per Minute (LPM) and portable oxygen is prescribed
- QG - Prescribed amount of oxygen is greater than 4 Liters Per Minute (LPM)

The modifier "QF" should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 LPM.

Effective April 1, 2017, stationary and portable oxygen and oxygen equipment QF fee schedule amounts will be added to the DMEPOS fee schedule file. The stationary oxygen and oxygen equipment QF fee schedule amount on the file will represent 100 percent of the stationary oxygen and oxygen equipment allowed fee schedule amount. The portable oxygen equipment add-on QF fee schedule amount on the file by state will represent the higher of:

- 50 percent of the monthly stationary oxygen payment amount (codes E0424, E0439, E1390, E1391) or
- The fee schedule amount for the portable oxygen add-on (codes E0431, E0433, E0434, E1392 or K0738).

The following are possible claims processing scenarios:

Scenario 1 – A claim for stationary oxygen equipment is submitted with the QG modifier. Medicare reviews the history and discovers that portable oxygen equipment was billed AND paid within the last 30 days prior to the date of service for the stationary oxygen equipment. Since the portable oxygen equipment add-on payment has already been made for this month, the volume adjustment add-on payment shall not be made in accordance with the rules of the statute. Use of the QG modifier is inappropriate in this case, and the claim should be returned as unprocessable.

Scenario 2 – A claim for stationary oxygen equipment is submitted with the QG modifier, and within 30 days the beneficiary needs portable oxygen equipment. In this case, the volume add-on payment has already been made for this month, so the portable oxygen equipment add –on payment shall not be made in accordance with the rules of the statute. The claim for the portable oxygen equipment should be returned as unprocessable.

Scenario 3 – A claim for stationary oxygen equipment is submitted with the QG modifier AND a claim for portable oxygen equipment is submitted with the same date of service. In this case EVERYTHING is returned as unprocessable due to the incorrect use of the modifier, and neither the claim for stationary oxygen equipment with the QG modifier nor the claim for portable oxygen equipment is valid.

NOTE: All these claims are being returned as unprocessable since there is no way for Medicare to know whether the first submitted claim was billed incorrectly or the subsequent claim was billed incorrectly.

Unprocessable claims will be returned with the following messages:

- Group Code: CO (Contractual Obligation)
- Claim Adjustment Reason Code (CARC) 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Additional Information

The official instruction, CR9848, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3730CP.pdf.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM10040

Related Change Request (CR) Number: 10040

Related CR Release Date: May 26, 2017

Effective Date: October 1, 2017

Related CR Transmittal Number: R3780CP

Implementation Date: October 2, 2017

Provider Type Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 100040 updates the remittance advice remark code (RARC) and claims adjustment reason code (CARC) lists and also instruct ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and RARCs, as appropriate, which provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment, are required in the remittance advice and coordination of benefits transactions.

The Centers for Medicare & Medicaid Services (CMS) instructs MACs to conduct updates based on the code update schedule that results in publication three times per year – around March 1, July 1, and November 1.

CMS provides a CR as a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in the CR, MACs must implement those updates on the date specified on the WPC website, which is at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated three times per year and may not match the CMS release schedule. For CR10040, the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website to obtain the comprehensive lists for both code sets and determine the changes included on the code list since the last code update CR (CR 9878).

Additional Information

The official instruction, CR10040, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3780CP.pdf.

Implement Operating Rules – Phase III ERA EFT: Core 360 Uniform Use of Claim CARC, RARC and CAGC Rule – Update from CAQH CORE

MLN Matters Number: MM10041

Related Change Request (CR) Number: 10041

Related CR Release Date: May 26, 2017

Effective Date: October 1, 2017

Related CR Transmittal Number: R3781CP

Implementation Date: October 2, 2017

Provider Type Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs and Home Health & Hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 10041 which instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2017. Make sure that your billing staff is aware of these changes.

In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background

The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act (ACA) of 2010.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to

adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Through the ACA, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The ACA defines operating rules and specifies the role of operating rules in relation to the standards.

Change Request (CR) 10041 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about June 10, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about March 1, 2017. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

You can find CARC and RARC updates at CARC/RARC News and CAQH CORE defined code combination updates at CAQH/CORE News.

Note: Per ACA mandate, all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC and CAGC combinations for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The official instruction, CR10041, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3781CP.pdf.

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10043

Related Change Request (CR) # 10043

Related CR Release Date: May 26, 2017

Effective Date: October 1, 2017

Related CR Transmittal Number: R3782CP

Implementation Date: October 2, 2017

Provider type affected

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider action needed

Change Request (CR) 10043 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These

codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status. This Recurring Update Notification (RUN) can be found in Chapter 31, Section 20.7. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

The codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the June 2017 committee meeting will be posted on these sites on or about July 1, 2017. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 10043.

The Centers for Medicare & Medicaid Services (CMS) will issue RUNs regarding the need for future updates to these codes. When instructed, Medicare contractors must update their claims systems to ensure that the current version of these codes is used in their claim status responses. Contractor and shared systems changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of this CR 10043.

Additional Information

The official instruction, CR10043, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3782CP.pdf.

Receive Your Medicare Payment Information Faster!

Would you like to receive faster payment notification from Medicare? What if we could eliminate mail and deposit time of your Medicare checks? The solution to both questions are just a few easy steps away. Sign up for Electronic Remittance Advices (ERAs) and Electronic Funds Transfer (EFT)!

ERAs are the recommended method for suppliers to receive their remittance advices and there are many benefits to switching to electronic:

- Faster communication and payment notification
- Faster account reconciliation through electronic posting
- Ability to create various reports
- Ability to search for information on claims

Ability to print the remittance advice with the free software supported by Medicare and provided by CEDI

Switching to ERAs is as easy as 1, 2, 3:

1. Verify you are capable of receiving the 835 transaction file.

- If you are a self-biller, verify this information with your software vendor.
- If you are using a 3rd party biller, verify the information with your billing service/ clearinghouse

2. Once the capability is confirmed, you will need to complete the required enrollment forms located the CEDI Web site www.ngscedi.com and follow the guided enrollment.

3. You will receive an e-mail confirmation once your request has been completed.

Once you have signed up to receive electronic remittance notices, consider signing up for electronic funds transfer as well! The EFTs are the most convenient method to receive your Medicare payments. EFT is the process through which payment on Medicare claims is electronically transferred directly to your bank account. This process eliminates mail and deposit time and is available to all DME POS suppliers at no cost. Other benefits of the EFT process include:

- Quicker payment
- Assurance of timely payment in the bank
- Prevention of lost or delayed checks
- Easier bank reconciliation
- Administration efficiency

To sign up for EFT, you or your authorized representative must complete the Authorization for Electronic Funds Transfer agreement form and send to your local Durable Medical Equipment Medicare Administrative Contractor (DME MAC). This form is available at http://www.cms.gov/cmsforms/downloads/CMS588.pdf.

ERNs and EFTs are a perfect way to ensure you receive your payments and your payment information as quickly as possible! For additional information, review the resources provided below.

Resources

Remittance Advice Information: An Overview

CEDI

Physicians! Are You Ordering Diabetic Shoes for Your Patients?

The following section outlines roles of various practitioners that are involved in the decision- making and provision process for Diabetic Shoes:

- Certifying Physician: The practitioner actively treating and managing the patient's systemic diabetic condition. This practitioner must be an M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) as outlined in the Social Security Act §1861(s) (12).
- Prescribing Practitioner: The Certifying Physician, a different MD or DO, physician's assistant (PA), nurse practitioner NP), clinical nurse specialist (CNS), or podiatrist (DPM). One of these practitioners may conduct the foot exam and write the detailed written orders required for Medicare's coverage of Therapeutic Shoes for Persons with Diabetes if the Certifying Physician does not complete the foot exam.
- Supplier: The person or entity that provides the shoes and/or inserts to the Medicare beneficiary and bills the Medicare program. A supplier may be a podiatrist, pedorthist, orthotist, prosthetist or other qualified individual. The Prescribing Practitioner may be the supplier.

Therapeutic shoes, inserts and/or modifications to therapeutic shoes are covered if all of the following criteria are met:

1. The beneficiary has diabetes mellitus (Reference diagnosis code section in Policy Article (A52501)); and

2. The certifying physician has documented in the beneficiary's medical record one or more of the following conditions:

- Previous amputation of the other foot, or part of either foot, or
- History of previous foot ulceration of either foot, or
- History of pre-ulcerative calluses of either foot, or
- Peripheral neuropathy with evidence of callus formation of either foot, or
- Foot deformity of either foot, or
- Poor circulation in either foot; and

3. The certifying physician has certified that indications (1) and (2) are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic

shoes. The Certifying Physician must:

- Have an in-person visit with the beneficiary during which diabetes management is addressed within six months prior to delivery of the shoes/inserts; and
- Sign the certification statement on or after the date of the in-person visit and within three months prior to delivery of the shoes/inserts.

4. Prior to selecting the specific items that will be provided; the supplier must conduct and document an in-person evaluation of the beneficiary.

5. At the time of in-person delivery to the beneficiary of the items selected, the supplier must conduct an objective assessment of the fit of the shoe and inserts and document the results.

The Certifying Physician must either:

- Personally document one or more of the qualifying foot conditions above in the medical record of an in-person visit within six months prior to delivery of the shoes/inserts; or
- Obtain, initial, date (prior to signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D. or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within six months prior to delivery of the shoes/inserts. In this scenario, a different practitioner conducts the foot examination.

The certification statement must be completed on or after the date of the in-person visit and within three months prior to delivery of the diabetic shoes by the supplier. The documentation in the medical record must support the information on the certification statement and the statement must be signed prior to, or the same day, as the order for the diabetic shoes and inserts. The certification statement by itself is not sufficient to meet the required documentation in the medical record and must be corroborated by the medical record.

Just a few reminders:

- The Certifying Physician **must** be an MD or DO that is managing the beneficiary's systemic diabetic condition.
- Another practitioner may conduct the foot exam that includes evidence of at least one of the qualifying foot issues. If this happens, the Certifying Physician must obtain a copy of that medical record, indicate agreement, sign and date it.
- The certification statement must be completed before the orders for the diabetic shoes.
- The Diabetic Shoe benefit is an annual benefit. Medicare will consider payment for one pair of diabetic shoes and up to three pairs of insoles per calendar year.
- The supplier must have valid detailed written orders in their possession prior to submitting the claim to the DME MAC.

All orders and medical records must meet CMS Signature Requirements

Following this guidance will help your patients and the Medicare program by verifying there is medical documentation to support the provisions for Therapeutic Shoes for Persons with

Diabetes, allow your patients to receive the items needed to treat their diabetic condition, and allow Medicare to pay claims appropriately.

Local Coverage Determinations for Therapeutic Shoes for Persons with Diabetes (L33369):

- Jurisdiction A
- Jurisdiction B
- Jurisdiction C
- Jurisdiction D

noridian Healthcare Solutions | DME Happenings
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