DME Happenings

Jurisdiction D
Issue 54
March 2017

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APPEALS

CLAIMS REVIEW

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

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Alphabetical Listing

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: https://med.noridianmedicare.com/web/jddme		

Fax	
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations	1-701-277-7886
Refunds to Medicare Immediate Offsets	1-701-277-7894
DME Recovery Auditor Offsets	1-701-277-7896
Medical Review Medical Documentation	1-701-277-7888
CERT Medical Documentation	1-701-277-7890

NHS Email Addresses	
NHS DME Customer Service	JDDme@noridian.com
Reopenings and Redeterminations	dmeredeterminations@noridian.com
NHS DME Endeavor	dmeendeavor@noridian.com

Mailing Addresses	
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian PO Box 6727 Fargo, ND 58108-6727	**Benefit Protection** Noridian Benefit Protection-DME PO Box 6736 Fargo, ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian PO Box 6737 Fargo, ND 58108-6737	**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 PO Box 6728 Fargo, ND 58108-6728	**DME Recovery Auditor Overpayments** Noridian PO Box 6759 Fargo, ND 58108-6759

Other DME MACs		
Jurisdiction A: NHS	1-866-419-9458	https://med.noridianmedicare.com/
Jurisdiction B: CGS	1-877-299-7900	www.cgsmedicare.com
Jurisdiction C: CGS	1-866-238-9650	www.cgsmedicare.com
Other Resources		
Pricing, Data Analysis and Coding	1-877-735-1326	www.dmepdac.com
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com/nsc
Common Electronic Data Interchange Help Desk	1-866-311-9184	www.ngscedi.com
Centers for Medicare & Medicaid Services		www.cms.gov

Infusion Drug Reimbursement Changes

Joint DME MAC Publication

For claims with dates of service on or after January 1, 2017, and consistent with Section 5004 of the 21st Century Cures Act, payment for infusion drugs furnished through a covered item of Durable Medical Equipment (DME) will be based on Section 1847A of the Social Security Act, meaning that most of the payments will be based on the Average Sales Price (ASP) plus 6 percent ("ASP +6") of these drugs.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. Please refer to the Fee Schedule section of the applicable DME MAC website for the most current information.

Payment for DME infusion drugs that do not have a payment limit based on section 1847A, including those DME infusion drugs that do not appear on the ASP drug pricing files, will be determined using the methodology in the Claims Processing Manual 100-04, Chapter 17, Section 20.1.3.

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."

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.

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

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

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.

ICD-10 Coding Revisions to NCDs

MLN Matters® Number:MM9861
Related Change Request (CR) #: CR 9861
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2016 - Unless otherwise noted in individual requirements
Related CR Transmittal #: R17920TN
Implementation Date: March 3, 2017 - MAC local systems; April 3, 2017 - FISS, MCS, CWF Shared systems

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9861 is the 10th maintenance update of ICD-10 conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are

a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, CR9540, CR9631, and CR9751; while others are the result of revisions required to other NCD-related CRs released separately. MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, MM9540, MM9631, MM9751 contain information pertaining to these CR's.

Background

The translations from ICD-9 to ICD-10 are not consistent 1-1 matches, nor are all ICD-10 codes appearing in a complete General Equivalence Mappings (GEMS) mapping guide or other mapping guides appropriate when reviewed against individual NCD policies. In addition, for those policies that expressly allow MAC discretion, there may be changes to those NCDs based on current review of those NCDs against ICD-10 coding. There may be certain ICD-9 codes that were once considered appropriate prior to ICD-10 implementation that are no longer considered acceptable, as of October 1, 2015.

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent, quarterly releases as needed.

CR9861 makes adjustments to the following 16 NCDs:

- NCD 40.1 - Diabetes Outpatient Self-Management Training
- NCD 40.7 - Outpatient Intravenous Insulin Treatment
- NCD 80.2 - Photodynamic Therapy (also NCD 80.2.1, 80.3, 80.3.1)
- NCD 80.11 - Vitrectomy
- NCD 100.1 - Bariatric Surgery
- NCD 110.4 – Extracorporeal Photopheresis
- NCD 110.18 - Aprepitant
- NCD 110.23 - Stem Cell Transplantation
- NCD 180.1 - Medical Nutrition Therapy
- NCD 190.1 – Histocompatibility Testing
- NCD 210.3 - Colorectal Cancer Screening
- NCD 220.4 - Mammograms
- NCD 220.6.17 - Positron Emission Tomography (PET) for Solid Tumors
- NCD 260.3.1 - Islet Cell Transplants
- NCD 260.5 - Intestinal and Multi-Visceral Transplants
- NCD 270.6 - Infrared Therapy Devices

The spreadsheets for the above NCDs are available at

https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9861.zip.

You should remember that coding and payment areas of the Medicare Program are separate and distinct from coverage policy/criteria. Revisions to codes within an NCD are carefully and thoroughly reviewed and vetted by the Centers for Medicare & Medicaid Services and are not intended to change the original intent of the NCD. The exception to this is when coding revisions are released as official implementation of new or reconsidered NCD policy following a formal national coverage analysis.

Your MACs will use default Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) messages where appropriate: Remittance Advice Remark Code (RARC) N386 with Claim Adjustment Reason Code (CARC) 50, 96, and/or 119, with Group Code PR (Patient Responsibility) or Group Code CO (Contractual Obligation), as appropriate.

Your MAC will not search their files to adjust previously processed claims but will adjust any claims that you bring to their attention if found appropriate to do so.

Additional Information

The official instruction, CR 9861 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017downloads/R1792OTN.pdf.

Healthcare Provider Taxonomy Codes (HPTCs) April 2017 Code Set Update

MLN Matters® Number: MM9869
Related Change Request (CR) #: CR 9869
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3723CP
Implementation Date: July 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9869 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use the standards adopted under this law for electronically transmitting certain health care transactions, including health care claims. The standards include implementation guides which dictate when and how data must be sent, including specifying the code sets which must be used. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

The National Uniform Claim Committee (NUCC) maintains the HPTC set for standardized classification of health care providers, and updates it twice a year with changes effective April 1 and October 1. These changes include the addition of a new code and addition of definitions to existing codes.

You should note that:

- Valid HPTCs are those that the NUCC has approved for current use.
- Terminated codes are not approved for use after a specific date.
- Newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.
- Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR9869 implements the NUCC HPTC code set that is effective on April 1, 2017, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. MACs will implement the April 2017 HPTC update as soon as they can after April 1, 2017, but not beyond July 3, 2017. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes.

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

- New items are green
- Modified items are orange
- Inactive items are red

Additional Information

The official instruction, CR 9869, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3723CP.pdf.

Medicare Deductible, Coinsurance and Premium Rates for 2017

MLN Matters® Number: MM9902
Related Change Request (CR) #: CR 9902
Related CR Release Date: December 2, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R103GI
Implementation Date: January 3, 2017

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) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2017 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness. When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital. An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible. A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Part B of the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

2017 Part A - Hospital Insurance (HI)

- Deductible: $1,316.00
- Coinsurance
  - $329.00 a day for 61st-90th day
  - $658.00 a day for 91st-150th day (lifetime reserve days)
  - $164.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- Base Premium (BP): $413.00 a month
- BP with 10 percent surcharge: $454.30 a month
- BP with 45 percent reduction: $227.00 a month (for those who have 30-39 quarters of coverage)
- BP with 45 percent reduction and 10 percent surcharge: $249.70 a month

2017 Part B - Supplementary Medical Insurance (SMI)

- Standard Premium: $134.00 a month
- Deductible: $183.00 a year
- Pro Rata Data Amount
  a. $125.73 1st month
  b. $57.27 2nd month
- Coinsurance: 20 percent

Additional Information

The official instruction, CR9902, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R103GI.pdf.

Guidance on Implementing System Edits for DMEPOS

MLN Matters® Number: MM9904
Related Change Request (CR) #: CR 9904
Related CR Release Date: February 10, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R17970TN
Implementation Date: October 2, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9904 updates CR7333 and CR9371 and informs MACs about changes related to Section 302 of the Medicare Modernization Act of 2003 (MMA). Section 302 added a new paragraph to the Social Security Act (the Act), Section 1834(a)(20) requiring the Secretary to establish and implement quality standards for suppliers of DMEPOS.

All DMEPOS suppliers that furnish such items or services required in the new paragraph, as the Secretary determines appropriate, must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. The covered items and services are defined in the Act.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) added a new subparagraph for implementing quality standards which state the Secretary shall require suppliers furnishing items and services on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. Make sure that your billing staffs are aware of these changes.

Background

Pursuant to subparagraph 1834(a)(20)(D) of the Act, the covered items and services are defined in Section 1834(a)(13), Section 1834(h)(4), and Section 1842(s)(2) of the Act. The covered items include:

- DME
- Medical supplies
- Home dialysis supplies and equipment
- Therapeutic shoes
- Parenteral and enteral nutrient, equipment and supplies
- Transfusion medicine
- Devices, prosthetics, and orthotics

Section 154(b) of MIPPA added a new subparagraph (F) to Section 1834(a)(20) of the Act. In implementing quality standards under this paragraph, the Secretary shall require suppliers furnishing items and services on or after October 1, 2009, directly or as a subcontractor for another entity, to have submitted evidence of accreditation by an accreditation organization designated by the Secretary. This subparagraph states that eligible professionals and other persons (defined below) are exempt from meeting the September 30, 2009, accreditation deadline unless the Centers for Medicare & Medicaid Services (CMS) determines that the quality standards are specifically designed to apply to such professionals and persons. The eligible professionals who are exempt from meeting the September 30, 2009, accreditation deadline (as defined in Section 1848(k)(3)(B)) include the following practitioners:

- Physicians (as defined in Section 1861(r) of the Act)
- Physical Therapists
- Occupational Therapists
- Qualified Speech-Language Pathologists
- Physician Assistants
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Certified Nurse-Midwives
- Clinical Social Workers
- Clinical Psychologists
- Registered Dietitians
- Nutritional professionals

Section 154(b) of MIPPA allows the Secretary to specify "other persons" that are exempt from meeting the accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such other persons. At this time, "such other persons" are specifically defined as the following practitioners:

- Orthotists
- Prosthetists
- Opticians
- Audiologists

All supplier types (except those listed above) who furnish items and services requiring accreditation, directly or as a subcontractor for another entity, must have submitted evidence of accreditation by an accreditation organization designated by the Secretary on or after October 1, 2009.

Medicare systems will have edits to check for accreditation on claims with HCPCS codes in the product categories designated by MIPPA as requiring accreditation. The edits will deny claims for these codes unless the DMEPOS supplier has been identified as accredited and verified on their CMS-855S or the DMEPOS supplier is currently exempt from meeting the accreditation requirements. When claims are denied, MACs will provide Remittance Advice Remark Code N211 – "Alert: You may not appeal this decision" and Claim Adjustment Reason Code CO-B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."

Additional Information

The official instruction, CR9904, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1797OTN.pdf.

Updates to the "Medicare Claims Processing Manual," Pub. 100-04, Chapters 12, 17 and 23 to Correct Remittance Advice Messages

MLN Matters® Number: MM9906
Related Change Request (CR) #: CR 9906
Related CR Release Date: February 24, 2017
Effective Date: May 25, 2017
Related CR Transmittal #: R3721CP
Implementation Date: May 25, 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

This article is based on Change Request (CR) 9906, which revises Chapters 12, 17, and 23 of the "Medicare Claims Processing Manual" (the manual) to ensure that all remittance advice coding is consistent with national standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual. MACs will ensure that they apply remittance advice coding as described in the revised manual sections. Make sure that your billing staffs are aware of these changes.

Background

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of Electronic Data Interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may be used. The rule requires specific codes, which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. CR9906 updates Chapters 12, 17, and 23 of the manual to reflect the standard format and to correct any non-compliant code combinations.

Additional Information

The official instruction, CR9906, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3721CP.pdf.

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

MLN Matters® Number: MM9911
Related Change Request (CR) #: CR 9911
Effective Date: for claims processed on or after October 2, 2017
Related CR Release Date: February 3, 2017
Related CR Transmittal #: R3715CP
Implementation Date: October 2, 2017

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/R3715CP.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.

The Process of Prior Authorization

MLN Matters® Number: MM9940
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

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 Master and Required Prior Authorization Lists, 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/Prior-Authorization-Initiatives/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.

Extension of the Transition to the Fully Adjusted DMEPOS Payment Rates Under Section 16007 of the 21st Century Cures Act

MLN Matters® Number: MM9968
Related Change Request (CR) #: CR 9968
Related CR Release Date: February 10, 2017
Effective Date: July 1, 2016
Related CR Transmittal #: R3716CP
Implementation Date: July 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for providers who bill Medicare Administrative Contractors (MACs) for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9968 provides instructions regarding the implementation of revised 2016 DMEPOS fee schedule amounts based on changes mandated by Section 16007 of the 21st Century Cures Act. These changes relate to the new Chapter 20, Section 20.6 (Phase-In for Competitive Bidding Rates in Areas Not in a Competitive Bid Area) of the "Medicare Claims Processing Manual," which is part of CR9968. Please make sure your billing staff is aware of these instructions.

Background

Effective January 1, 2017, legislation requires changes to the July and October 2016 fee schedule amounts for certain items. Section 1834(a)(1)(F)(ii) of the Social Security Act (the Act) mandates adjustments to the fee schedule amounts for certain DME items furnished on or after January 1, 2016, in areas that are not competitive bid areas, based on information from competitive bidding programs for DME.

Regulations at Section 414.210(g)(9) phased in these adjusted fees so that from January 1, 2016, through June 30, 2016, the fee schedule amount in non-bid areas was based on 50 percent of the adjusted payment amount established using competitive bidding information and 50 percent of the unadjusted fee schedule amount (the 2015 fee schedule amount updated by the 2016 covered item update). Beginning July 1, 2016, the fee schedule amounts for non-bid areas reverted to 100 percent of the adjusted payment amounts determined using competitive bidding information.

Section 16007 of the 21st Century Cures Act changes the 2016 fee schedule transition period so that payment based on 50 percent of the adjusted payment amount established using competitive bidding information and 50 percent of the unadjusted fee schedule amount extends from June 30, 2016, to December 31, 2016. Section 16007 also changes from July 1, 2016, to January 1, 2017, the date that payment based on 100 percent of the adjusted payment amounts in non-bid areas is effective.

To supplement Section 16007 for dates of service July 1, 2016, through December 31, 2016, the 50/50 blend fee schedules have been recalculated so that the adjusted portion of the payment blend utilizes July 1, 2016, adjusted fees. Also, the KE modifier fee schedules for items bid in the initial Round 1 Competitive Bidding Program (CBP) have been added back to the fee schedule file for this extended phase-in period. The KE modifier was added to the DMEPOS fee schedule file as part of the January 2009 fee schedule update and described items that were bid under the initial Round 1 CBP but were used with non-competitive bid base equipment. Suppliers should submit a request for reopening if their claim for dates of service between July 1, 2016, and December 31, 2016, should have been processed with the KE modifier.

The revised July 1, 2016, through December 31, 2016, DMEPOS and parenteral and enteral nutrition (PEN) fee schedule files will be made available to the DME MACs. The previously posted July 2016 and October 2016 DMEPOS and PEN public use files will be revised to reflect the new fee schedule amounts associated with the extension of the transition period. MACs will accept the KE modifier on the adjusted claims. In addition, for claims that the KE modifier would have been applicable to, the supplier may adjust the claim or notify MACs to adjust the claims after the mass adjustments for the 50/50 fee blend have been completed.

Your MAC will reprocess affected claims and adjust claims that were previously paid. The MACS will begin this claim adjustment process once the revised fee schedule files are available.

Additional Information

The official instruction, CR9968, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3716CP.pdf.

Revised CMS - 855S Application for DMEPOS Suppliers

MLN Matters® Number: SE17004
Article Release Date: January 5, 2017
Effective Date: January 1, 2017
Implementation Date: December 31, 2016

Provider Types Affected

This MLN Matters® Article is intended for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) informs DMEPOS suppliers that they must use the revised CMS-855S (Medicare Enrollment Application – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers) application beginning December 31, 2016.

The revised application will be posted on the CMS Forms List (go.usa.gov/cuu5Y) by mid-summer. The National Supplier Clearinghouse (NSC) MAC may accept both the current and revised versions of the CMS-855S through December 31, 2016, after which the revised CMS-855S application must be submitted. After December 31, 2016, the NSC MAC will return any newly submitted CMS-855S applications using the previous version (01/13) to the supplier with a letter explaining that the CMS-855S has been updated and the current version of the CMS-855S (05/16) must be submitted. Make sure that your billing staffs are aware of these changes.

Background

DMEPOS suppliers must use the revised CMS-855S application starting December 31, 2016.

This revision of the CMS 855S simplifies and clarifies the current data collection and removes obsolete and/or redundant data collection. Grammar and spelling errors were corrected as well. Limited informational text has been added within the application form. In addition, links to websites are added to provide helpful instructions when greater detail is needed by the supplier, for example:

FYI

- The "Process to Obtain Medicare Approval" section of the instructions added the application fee and fingerprinting requirements, complete with website links and a telephone number for additional information, if the supplier desires additional information;
- A note was added instructing non-profit government agencies that they need not submit an IRS Form 501(c)(3) to prove its non-profit status in sections 2, 8, and 12; and
- CMS added a website offering guidance on DMEPOS supplier licensure requirements in Section 2.

To clarify current data collection, Section 3D (Products and Services Furnished by This Supplier) is updated to differentiate between used and new equipment for support surfaces, creating an option for the DMEPOS supplier to indicate whether the supplier provides new or used support surfaces, rather than having one category for both new and used (as on the previous version of the CMS 855S). In addition, "Hemodialysis Equipment and/or Supplies" and "Home Dialysis Equipment and/or Supplies" have been deleted from this section as they are only payable to Home Dialysis facilities which are solely a Part A benefit. "External Infusion Pumps and/or Supplies" as well as "Insulin Infusion Pumps and/or Supplies" have been split into two separate products - the pump itself and the supplies independent of the pump. The previous product categories were misleading because the supplier may not supply both products. "Invasive Mechanical Ventilation Devices" were replaced with the more accurate "Ventilators: All Types – Not CPAP or RAD" and the word "repairs" was added to the standard manual and standard power wheelchair accessories product categories in order to be more in sync with accreditation coding.

No additional material data collection has been added in this revision.

Additional Information

Visit the Medicare Provider Supplier Enrollment webpage at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html for more information.

APPEALS

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. - 6 p.m. CT 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.

CLAIMS REVIEW

Ankle-Foot Orthosis (HCPCS L1960, L1970 & 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 September 2016 through December 2016 are as follows:

- The L1960 review involved 188 claims, of which 145 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 75%.
- The L1970 review involved 283 claims, of which 210 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 71%.
- The L4360 review involved 326 claims, of which 320 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

Top Denial Reasons

- Documentation does not support custom fit criteria.
- Documentation does not support custom fabricated criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) was not received.

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

Blood Glucose Test Strips (HCPCS A4253) 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) A4253KS. 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 September 2016 through November 2016, are as follows:

- The A4253KS review involved 11,002 claims, of which 6,603 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 55%.
  - 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.
  - Proof of Delivery(POD) was not received.

For complete details, see Blood Glucose Test Strips (HCPCS A4253) Quarterly Results of Documentation Compliance Review.

External Infusion Pumps (HCPCS J1817) 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) J1817. The quarterly edit effectiveness results from September 2016 through December 2016 are as follows:

- The J1817 review involved six claims, of which six were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **100%**.

Top Denial Reasons

- 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, External Infusion Pumps (HCPCS J1817) 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 July 2016 through October 2016 are as follows:

- The J2260 review involved nine claims, of which five were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **36%**.

The top reasons for denial are:

- Documentation does not support coverage criteria.
- Detailed Written Order (DWO) was not received or is incomplete.
- Proof of Delivery (POD) is dated prior to the date of service of the claim.

For complete details, see External Infusion Pumps (HCPCS J2260) 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 July 2016 through October 2016 are as follows:

- The E0250 review involved 178 claims, of which 101 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **58%**.

The top reasons for denial are:

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

For complete details, see Hospital Beds (HCPCS E0250) Quarterly Results of Service Specific Prepayment 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 July 2016 through October 2016 are as follows:

The L4361 review involved 591 claims, of which 401 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 68%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) was not received or was missing information.
- Documentation does not support coverage criteria.
- Detailed Written Order (DWO) was not received.

For complete details, see Ankle-Foot/Knee-Ankle-Foot Orthosis (HCPCS L4361) Quarterly Results of Service Specific Prepayment 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 July 2016 through October 2016 are as follows:

- The L1832 review involved 153 claims, of which 152 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.
- The L1843 review involved 114 claims, of which 115 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.

The top reasons for denial are:

- Documentation does not support custom fit criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Proof of Delivery (POD) was not received.

For complete details, 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 September 2016 through December 2016 are as follows:

- The L1833 review involved 660 claims, of which 600 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **93%**.

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) was not received.
- Detailed Written Order (DWO) 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 July 2016 through October 2016 are as follows:

The K0001 review involved 860 claims, of which 598 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 65%.

The K0003 review involved 235 claims, of which 195 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria for a manual wheelchair.
- Documentation does not support coverage criteria for a lightweight wheelchair.
- Detailed Written Order (DWO) is incomplete or missing elements.

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

Nebulizer (HCPCS Q4074) 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 Q4074. This review was initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

- The Q4074 review involved 111 claims, of which 52 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 20%.

The top reasons for denial are:

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

- Proof of Delivery (POD) is invalid.
- Refill request was not received or was incomplete.
- Documentation does not support coverage criteria.

For complete details, see Nebulizer (HCPCS Q4074) Results of Service Specific Prepayment Probe 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 August 2016 through November 2016 are as follows:

- The J7682 review involved 26 claims, of which 18 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation submitted is dated after the date of service.
- Refill request documentation is incomplete or missing elements.
- Documentation does not support coverage criteria.

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

Negative Pressure Wound Therapy Pumps (HCPCS E2402) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E2402. The final edit effectiveness results from January 2016 through December 2016 are as follows:

- The E2402 review involved 484 claims, of which 278 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 52%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is invalid or missing elements.
- Documentation does not support coverage criteria.
- Medical documentation was not received.

For complete details, see Negative Pressure Wound Therapy Pumps (HCPCS E2402) Final Edit Effectiveness 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 E0431. The quarterly edit effectiveness results from August 2016 through November 2016 are as follows:

- The E0431 review involved 371 claims, of which 219 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 62%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- The medical record documentation does not support the alternative treatment measures have been tried or considered and deemed clinically ineffective prior to initiating home oxygen therapy.
- The medical record documentation does not support severe underlying lung disease.
- The medical record documentation does not support the blood gas study was obtained while the beneficiary was in a chronic state.

For complete details, 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 July 2016 through October 2016 are as follows:

- The E0434 review involved 64 claims, of which 43 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 71%.
- The E0439 review involved 176 claims, of which 102 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 57%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Written Order Prior to Delivery (WOPD) is incomplete or missing elements.
- The medical record documentation does not support the blood gas study was obtained while the beneficiary was in a chronic state.

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

Positive Airway Pressure (PAP) Devices (HCPCS E0601KH, 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 July 2016 through November 2016 are as follows:

- The E0601KH review involved 2,880 claims, of which 1,201 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 39%.
- The E0601KJ review involved 1,813 claims, of which 870 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 50%.

The top reasons for denial were:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria beyond the first three months of therapy.
- Documentation does not support coverage criteria.
- Written Order Prior to Delivery (WOPD) is incomplete or missing elements.

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

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 July 2016 through November 2016 are as follows:

- The E0181 review involved 149 claims, of which 92 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.
- The E0185 review involved 145 claims, of which 89 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 63%.

The top reasons for denial are:

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

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

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 September 2016 through December 2016 are as follows:

- The L0631 review involved 138 claims, of which 131 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 94%.
- The L0637 review involved 137 claims, of which 131 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 July 2016 through October 2016 are as follows:

- The L0648 review involved 402 claims, of which 315 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 78%.
- The L0650 review involved 859 claims, of which 750 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 87%.

The top reasons for denial were:

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

For complete details, 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 July 2016 through November 2016 are as follows:

- The TLSO review involved 26 claims, of which 26 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.
- The LSO review involved 291 claims, of which 290 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.
- The SO review involved 25 claims, of which 23 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 97%.
- The LO review involved 88 claims, of which 88 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

The top reasons for denial are:

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

For complete details, see Spinal Orthosis Quarterly Results of Service Specific Prepayment 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 E0730. The quarterly edit effectiveness results from August 2016 through November 2016 are as follows:

- The E0730 review involved 7 claims, of which 7 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **100%**.

Top Denial Reasons

- The medical record documentation contains a practitioner's signature which does not comply with the Centers for Medicare & Medicaid Services signature requirements.
- Proof of Delivery (POD) is incomplete or missing elements.
- Documentation does not demonstrate chronic, intractable pain other than chronic low back pain.
- Documentation does not demonstrate re-evaluation at the end of the trail period. TENS usage for chronic low back pain does not require a trial period or re-evaluation.

For complete details, 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 September 2016 through December 2016 are as follows:

- The A5500 review involved 2,325 claims, of which 1,694 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **72%**.

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.
- Proof of Delivery (POD) was not received.

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 July 2016 through October 2016 are as follows:

- The A4351 review involved 1,361 claims, of which 879 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 57%.
- The A4353 review involved 197 claims, of which 177 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 85%.
- The A4358 review involved 1,219 claims, of which 900 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

The top reasons for denials are:

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

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

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.

CLAIM SUBMISSION

How to Use Modifier RB

Repairs to items which a beneficiary owns are covered when necessary to make the items serviceable. Any Medicare-enrolled supplier can perform repairs on beneficiary-owned equipment.

Repairs (parts and labor) of DMEPOS items are performed on the base item. The replacement of parts or components that make up the base item is considered to be a repair. Effective for claims with dates of service on or after October 1, 2016, when billing for replacement parts to repair base equipment the RB modifier must be utilized. All repair parts billed with the RB modifier will be paid as a lump sum purchase, regardless of whether the beneficiary is within or outside of a competitive bidding area, or whether the HCPCS code is a competitive bid item or not, or whether it is described by a code for miscellaneous (not otherwise classified or specified) items or not.

Reminder - Medicare does not separately reimburse for repairs of:

- Items in the frequent and substantial servicing payment category
- Oxygen equipment
- Items in the capped rental payment category during the capped rental period
- Items covered under a manufacturer's or supplier's warranty
- Previously denied items

The furnishing of new separately payable accessories that were not part of the initial base item is considered to be replacement. When billing for replacement parts, in addition to the RB modifier, the NU pricing modifier and informational modifiers (KH, KX, RT, or LT, etc.) are necessary. The pricing modifier

should directly follow the HCPCS code on the claim line. It is recognized that this may create situations where the overflow modifier 99 is needed. Modifier 99 must be utilized when it is necessary to bill with more than four modifiers on a single claim line. The overflow modifiers must then be placed in the claim narrative.

When replacing items in the capped rental category, the KH modifier must be added to the claim.

The following modifier combinations are not valid and will be rejected as unprocessable:

- RB and KY
- RB and KE
- RB and RR

The **KY** modifier cannot be used with a replacement associated with a repair to the base item when the RB modifier is required. The KY modifier may be used when the competitive bid accessory is used on a non-bid complex base, K0005, E1161, K0835-K0864 and the beneficiary resides in a competitive bid area. This enables the system to use the 2016 Adjusted Fee Schedule rather than the Single-Payment Amount (SPA).

Using Modifier JW - Reminder

For dates of service on or after January 1, 2017, suppliers must use Modifier JW when billing for discarded drugs and biologicals. The Local Coverage Determinations (LCDs) have been updated to include the JW modifier requirements for the following LCDs:

- External Infusion Pumps
- Intravenous Immune Globulin (IVIG)
- Nebulizers

For more information and how to bill these services, view the Correct Coding – JW Modifier Use – Revised – Effective for Claims with Dates of Service on or After January 1, 2017 article.

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

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

MLN Matters® Number: MM9893
Related Change Request (CR) #: CR 9893
Related CR Release Date: February 3, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R17870TN
Implementation Date: October 2, 2017

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 Change Request (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-aide 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-aide 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/R1787OTN.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.

DMEPOS CBP Quarterly Update April 2017

MLN Matters® Number: MM9971
Related Change Request (CR) #: CR 9971
Related CR Release Date: February 3, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3702CP
Implementation Date: April 3, 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) 9971 provides the April 2017 quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The Centers for Medicare & Medicaid Services (CMS) issued CR9771 to provide the DMEPOS Competitive Bidding Program (CBP) April 2017 quarterly update.

CR9971 provides specific instructions to your Durable Medical Equipment (DME) MAC for implementing updates to the DMEPOS Competitive Bidding Program (CBP) Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. DMEPOS CBP quarterly updates are available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home. At the site, click on the quarterly updates link on the left side of the page.

Background

The DMEPOS CBP was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected DMEPOS items with a competitive bid process. 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, a competition among suppliers who operate in a particular competitive bidding area is conducted. Suppliers are required to submit a bid for selected products. 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 supplier's 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.

Additional Information

The official instruction, CR9971, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3702CP.pdf.

Correct Coding - 2017 HCPCS Code Annual Update

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - 2017 HCPCS Code Annual Update" is now available on our (Noridian) website.

View the complete Correct Coding – 2017 HCPCS Code Annual Update webpage.

Correct Coding - Diapers and Underpads

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Diapers and Underpads" is now available on our (Noridian) website.

View the complete Correct Coding - Diapers and Underpads webpage.

Correct Coding - Diapers and Underpads

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Diapers and Underpads" is now available on our (Noridian) website.

View the complete Correct Coding - Diapers and Underpads 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: This January 2016 revision corrects a clerical error instructing suppliers to obtain a recertification DIF when length of need expires and the ordering physician extends the length of need. Recertification DIF information has been removed from the article.

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

DME MACs LCD Format Change

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "DME MACs LCD Format Change" is now available on our (Noridian) website.

View the complete DME MACs LCD Format Change webpage.

Billing Instruction - Hospital Beds and Pressure Reducing Support Surfaces

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Billing Instruction – Hospital Beds and Pressure Reducing Support Surfaces" is now available on our (Noridian) website.

View the complete Billing Instruction – Hospital Beds and Pressure Reducing Support Surfaces webpage.

Correct Coding - LIM Innovation Below Knee Socket - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - LIM Innovation Below Knee Socket - Revised" has been updated.

Summary of changes: The correct combination of HCPCS codes to bill Medicare table was updated.

View the complete Correct Coding – LIM Innovation Below Knee Socket - Revised webpage.

Correct Coding - Manual Wheelchairs Constructed of Titanium

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Manual Wheelchairs Constructed of Titanium" has been updated.

View the complete Correct Coding – Manual Wheelchairs Constructed of Titanium webpage.

Correct Coding - Negative Pressure Wound Therapy (NPWT)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Negative Pressure Wound Therapy" has been updated.

View the complete Correct Coding – Negative Pressure Wound Therapy (NPWT) webpage.

Correct Coding - NOC HCPCS Codes Used for Drugs

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Not Otherwise Classified (NOC) HCPCS Codes Used for Drugs" is now available on our (Noridian) website.

View the complete Correct Coding – Not Otherwise Classified (NOC) HCPCS Codes Used for Drugs webpage.

Correct Coding - Oral Appliances Not Used For the Treatment of Obstructive Sleep Apnea

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Oral Appliances Not Used For the Treatment of Obstructive Sleep Apnea" is now available on our (Noridian) website.

View the complete Correct Coding – Oral Appliances Not Used For the Treatment of Obstructive Sleep Apnea webpage.

LCD and Policy Article Revisions Summary for December 29, 2016

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for December 29, 2016" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for December 29, 2016 webpage.

Correct Coding - WHILL Powered Personal Mobility Devices - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - WHILL Powered Personal Mobility Devices - Revised" has been updated.

Summary of Changes: This article updates the HCPCS Code assignment for WHILL Model M.

View the complete Correct Coding - WHILL Powered Personal Mobility Devices - Revised webpage.

MLN Connects Provider eNews – December 8, 2016

MLN Connects® Provider eNews for Thursday, December 8, 2016
View this edition as a PDF

News & Announcements

- Keeping Medicare's Promise with MACRA
- Submit Quality Payment Program Comments by December 19
- EHR Incentive Programs: Information on CY 2017 and Stage 3 Program Requirements
- National Influenza Vaccination Week: What Does Medicare Cover?

Provider Compliance

- Billing for Ambulance Transports

Upcoming Events

- 2016 Hospital Appeals Settlement Update Call — December 12
- MIPS Webinar — December 13
- IRF-PAI Therapy Information Data Collection Call — January 12

Medicare Learning Network® Publications & Multimedia

- Exceptions for Late Hospice Notices of Election Delayed by Medicare Systems MLN Matters Article — New
- SNF Quality Reporting Program Video Presentation — New
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Revised
- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet — Reminder

MLN Connects Provider eNews – December 15, 2016

MLN Connects® Provider eNews for Thursday, December 15, 2016
View this edition as a PDF

News & Announcements

- CMS Releases Person and Family Engagement Strategy
- Medicare Outpatient Observation Notice CMS-10611 Available
- Quality Payment Program Patient Relationship Categories List: Comment by January 6
- IRF and LTCH QRP Preview Reports Available: Review by January 10
- ICD-10 Code Updates: Impact on Medicare Quality Programs

Provider Compliance

- Compliance Programs and Fraud and Abuse Laws

Claims, Pricers & Codes

- January 2017 Average Sales Price Files Available

Upcoming Events

- MACRA 101 Webinar Series — December 16, 20, and 21
- Quality Payment Program: Electing MIPS vs. APMs Webinar — December 19
- IRF-PAI Therapy Information Data Collection Call — January 12
- ESRD QIP: Payment Year 2020 Final Rule Call — January 17

- Hospice Quality Reporting Program Provider Training — January 18

Medicare Learning Network® Publications & Multimedia

- Comprehensive CJR Model: SNF 3-Day Rule Waiver MLN Matters® Article — New
- Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New
- IRF and LTCH Quality Reporting Program Call: Audio Recording and Transcript — New
- LTCH Prospective Payment System Booklet — Revised
- Mass Immunizers and Roster Billing Fact Sheet — Reminder

MLN Connects Provider eNews – December 22, 2016

MLN Connects® Provider eNews for Thursday, December 22, 2016
View this edition as a PDF

News & Announcements

- Increased Transparency and Quality Information via New Compare Sites and Data Updates
- Additional Opportunities for Clinicians under the Quality Payment Program
- HHS Finalizes New Medicare Alternative Payment Models
- CMS Releases Second Year of Home Health Utilization and Payment Data
- Hospice Quality Measure Reports Available
- New ST PEPPER Available
- First Two DME Items Subject to Prior Authorization
- Part D Prescribers: Date Change and Phased Enforcement
- 2017 eCQM Logic Flows for Eligible Clinicians Available
- EHR Incentive Programs: Prepare for 2016 Attestation
- EHR Incentive Programs FAQs on 2017 OPPS/ASC Final Rule

Provider Compliance

- Office of Inspector General Exclusion Authorities

Claims, Pricers & Codes

- Pricing and Payment Changes for DME Infusion Drugs Effective January 1, 2017

Upcoming Events

- IRF-PAI Therapy Information Data Collection Call — January 12
- ESRD QIP: Payment Year 2020 Final Rule Call — January 17
- Home Health Groupings Model Technical Report Call — January 18
- Comparative Billing Report Webinar on Knee Orthoses — February 8

Medicare Learning Network® Publications & Multimedia

- Continuation of HH Probe and Educate Medical Review Strategy MLN Matters® Article — New
- Dementia Care and QAPI Call: Audio Recording and Transcript — New
- ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets Educational Tool — Revised
- Medicare Billing: 837P and Form CMS-1500 Fact Sheet — Revised
- DMEPOS Accreditation Fact Sheet — Reminder
- MREP Software Fact Sheet — Reminder
- Continuing Education Credits for Web-Based Training Courses

MLN Connects – January 5, 2017

Best wishes for a happy and healthy 2017. Your MLN Connects® Provider eNews has a new name and design for the new year. Let us know what you think. MLN Connects still delivers the weekly Medicare news you expect but with a fresh new style from the Medicare Learning Network® (MLN).

MLN Connects® for Thursday, January 5, 2017

View this edition as a PDF

News & Announcements

- Apply for Clinical Practice Improvement Activities and Measurement Study by January 31
- Updated ESRD PPS Website
- Comparative Billing Report on Physical Therapy in February
- EHR Incentive Programs: New Attestation Resources
- Implementation Guide for QRDA-III Eligible Clinician Programs Available
- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2017

Provider Compliance

- Duplicate Claims Will Not be Paid

Claims, Pricers & Codes

- Fee Schedule Amounts for Group 3 Power Wheelchair Accessories and Cushions

Upcoming Events

- ESRD QIP: Payment Year 2020 Final Rule Call — January 17
- Home Health Groupings Model Technical Report Call — January 18
- Hospice Quality Reporting Program Provider Training — January 18
- Home Health Quality of Patient Care Star Rating Call — January 19
- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network Publications & Multimedia

- Quality Payment Program Video Presentation — New
- Hospital Settlement Call: Audio Recording and Transcript — New
- Medicare Overpayments Fact Sheet — Revised
- PECOS for Provider and Supplier Organizations Fact Sheet — Revised
- Long-Term Care Hospital Prospective Payment System Booklet — Reminder
- Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Reminder

MLN Connects – January 12, 2017

MLN Connects® for Thursday, January 12, 2017

View this edition as a PDF

News & Announcements

- Addressing the Opioid Epidemic: Keeping Medicare and Medicaid Beneficiaries Healthy
- Post-Acute Care TOH Quality Measures Pilot Study: Respond by January 17
- Clinical Laboratories: Prepare Now to Report Lab Data through March 31

- Chronic Care Management Services Changes for 2017
- eCQI Resource Center Integrated with USHIK
- eCQM Value Sets for 2017 Performance Period: Addendum Available
- Medicare Quality Programs: ICD-10 Code Updates and Impact to 4th Quarter 2016
- January is Cervical Health Awareness Month

Provider Compliance

- CMS Provider Minute: CT Scans Video

Upcoming Events

- ESRD QIP: Payment Year 2020 Final Rule Call — January 17
- Home Health Groupings Model Technical Report Call — January 18
- Home Health Quality of Patient Care Star Rating Call — January 19
- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network Publications & Multimedia

- Additional Guidance for Clinical Laboratories as Data Reporting Begins MLN Matters Article — New
- Revised CMS 855S Application: DMEPOS Suppliers MLN Matters Article — New
- Chronic Care Management Services Changes for 2017 Fact Sheet — New
- How to Use the Medicare Coverage Database Booklet — Revised
- SNF Prospective Payment System Booklet — Revised
- Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised
- HH Prospective Payment System Booklet — Revised
- IRF Prospective Payment System Fact Sheet — Revised
- Chronic Care Management Services Fact Sheet — Revised
- Medicare Vision Services Fact Sheet — Revised
- Swing Bed Services Fact Sheet — Revised
- Mass Immunizers and Roster Billing Fact Sheet — Revised

MLN Connects – January 19, 2017

MLN Connects® for Thursday, January 19, 2017
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News & Announcements

- Over 40 Million Medicare Beneficiaries Utilized Free Preventive Services in 2016
- Prosthetics and CustomFabricated Orthotics Practitioners and Suppliers: Establishment of Special Payment Provisions and Requirements
- eCQM Data: Extension of 2016 Reporting Deadline to March 13
- EHR Incentive Program: Attest to 2016 Program Requirements by February 28
- EHR Incentive Programs: Calculations for Objectives and Measures Requiring Patient Action
- CMS Releases ESRD QIP Performance Score Reports for PY 2017
- New Care Management Webpage
- Provider Enrollment Application Fee Amount for CY 2017

- 2017 Annual Stationary Oxygen Budget Neutrality Calculations
- Glaucoma Awareness Month: Make a Resolution for Healthy Vision

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Claims, Pricers & Codes

- OPPS Hospital Claim Issues

Upcoming Events

- Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24

Medicare Learning Network Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 2] — New
- Medicare Parts C and D General Compliance Web-Based Training Course — Revised
- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training Course — Revised
- Health Care Professional Frequently Used Web Pages Educational Tool — Revised
- ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets Educational Tool — Reminder

MLN Connects – February 2, 2017

MLN Connects® for Thursday, February 2, 2017
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News & Announcements

- Clinical Laboratories: Prepare Now to Report Lab Data through March 31
- Updated Clinical Laboratory Fee Schedule Website
- Teaching Hospitals Receiving FTE Resident Caps Due to Hospital Closures
- February is American Heart Month

Provider Compliance

- Hospital Discharge Day Management Services

Upcoming Events

- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

Medicare Learning Network Publications & Multimedia

- Telehealth Services Fact Sheet — Revised
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Revised
- Home Oxygen Therapy Booklet — Revised
- MLN Suite of Products & Resources for Rural Health Providers Educational Tool — Revised

MLN Connects – February 9, 2017

MLN Connects® for Thursday, February 9, 2017
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News & Announcements

- Clinical Laboratories: Easier to Report Lab Data

Claims, Pricers & Codes
- January 2017 OPPS Pricer File

Upcoming Events
- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

MLN Connects – February 16, 2017

MLN Connects® for Thursday, February 16, 2017
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News & Announcements
- Influenza Activity Continues: Are Your Patients Protected?

Upcoming Events
- Understanding and Promoting the Value of Chronic Care Management Services Call — February 21
- What's New with Physician Compare Webinar — February 21 and 23
- Looking Ahead: The IMPACT Act in 2017 Call — February 23

Medicare Learning Network Publications & Multimedia
- Medicare Home Health Benefit Booklet — Revised
- Medicare Costs at a Glance: 2017 Educational Tool — Revised
- CMS Provider Minute Video: Nasal Endoscopy — Reminder

MLN Connects – February 23, 2017

MLN Connects® for Thursday, February 23, 2017
View this edition as a PDF

News & Announcements
- CMS Awards Approximately $100 Million to Help Small Practices Succeed in the Quality Payment Program
- NHSN Data Submission Deadline for IRF and LTCH QRP: Extended to May 15

Provider Compliance
- Reporting Changes in Ownership

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
- Comparative Billing Report on Physical Therapy Webinar — March 29

Medicare Learning Network Publications & Multimedia
- Collecting Data on Sexual Orientation and Gender Identity in Health Care Settings Web-Based Training Course — New
- Audio Recordings and Transcripts from Recent Calls — New
- Medicare Outpatient Observation Notice Instructions MLN Matters Article — Revised
- Acute Care and the IPPS Web-Based Training Course — Revised

Physicians! Are You Ordering Nebulizers and Inhalation Medication for Your Patient?

Medicare will consider coverage of a nebulizer, compressor and related accessories when the patient's medical record verifies the patient has a condition that requires certain inhalation medication (as outlined below).

For the nebulizer compressor only (E0570, E0575, E0580, E0585, K0730), the following is required prior to delivery:

Nebulizer - Documentation prior to delivery	Nebulizer - Prescription prior to delivery
A face-to face-visit within six months prior to prescribing: • Documenting the patient was evaluated and/or treated for the condition supporting need for the item(s) ordered	A five element order (5EO) with the following: • Patient name • Item ordered • National Provider Identifier (NPI) of prescribing practitioner • Date of the order • Prescribing practitioner signature

For any item provided based on physician contact with a DME supplier to provide the service (i.e., dispensing order), the supplier must obtain a detailed written order (DWO) before submitting a claim. The detailed written order must contain:

Detailed Written Order (DWO) elements prior to billing	Items provided on a periodic basis, inhalation drugs and related accessories/supplies must include
Beneficiary's name	Item(s) to be dispensed
Prescribing practitioner's name	Frequency of use
Date of the order	Quantity to be dispensed
Detailed description of the item(s)	Number of refills
Prescribing practitioner's signature and signature date	

The DME MAC Nebulizers Local Coverage Determination (LCD) L33370 outlines the coverage criteria for the nebulizer, related compressor, and FDA –approved nebulizer drugs and other related accessories/ supplies.

The charts below provide the various types of nebulizers and inhalation drugs covered by Medicare for specific disease categories.

NEBULIZERS

Small Volume NebuliObstzer A7003-A7005 Compressor E0570				
Obstructive Pulmonary Disease	**Cystic Fibrosis**	**Cystic Fibrosis or Bronchiectasis**	**HIV, Pneumocystosis, or Organ Transplants**	**Persistent Pulmonary Secretions**
Group 8 Codes	**Group 9 Codes**	**Group 10 Codes**	**Group 4 Codes**	**Group 7 Codes**
Albuterol (J7611, J7613)	**Dornase Alpha J7639**	**Tobramycin J7682**	**Pentamidine J2545**	**Acetylcysteine J7608**
Arformoterol (J7605)				
Budesonide (J7626)				
Cromolyn (J7631)				
Formoterol (J7606)				
Ipratropium (J7644)				
Levalbuterol (J7612, J7614)				
Metaproterenol (J7669)				

Large Volume Nebulizer A7007, A7017 • Compressor E0565, E0572 Water/Saline A4217 or A7018 or Combination Code E0585			
Persistent thick and tenacious Pulmonary Secretions			
Cystic Fibrosis	**Bronchiectasis**	**Tracheostomy**	**Tracheobronchial Stent**
(Group 5 Codes)			
Acetylcysteine J7608			
Diagnosis codes that support medical necessity Group 5 codes section for applicable diagnoses.			

Small Volume Ultrasonic Nebulizer E0574 Accessories A7013, A7014, A7016
Pulmonary Hypertension with Additional Criteria
(Group 1 Codes)
Tresprostinil J7686

Compressor E0565 or E0572 • Filtered Nebulizer A7006		
Persistent thick and tenacious Pulmonary Secretions		
HIV	**Pneumocystosis**	**Complications of Organ Transplants**
(Group 1 Codes)		
Pentamidine J2545		

NEBULIZERS

The Nebulizers Local Coverage Determination (LCD) L33370 provides the usual maximum frequency of replacement of related accessories/supplies, as well as, the maximum milligrams per month of inhalation drugs that are reasonable and necessary.

Please note: If none of the drugs (as outlined above) used with a nebulizer are covered; the compressor, the nebulizer, and other related accessories/supplies will be denied as not reasonable and necessary.

Local Coverage Determinations for Nebulizers

Jurisdiction A: https://med.noridianmedicare.com/documents/2230703/7218263/Nebulizers/ db04b968-5cd0-4445-9707-0fe51d34ec80

Jurisdiction B: http://www.cgsmedicare.com/jb/coverage/lcdinfo.html

Jurisdiction C: http://www.cgsmedicare.com/jc/coverage/lcdinfo.html

Jurisdiction D: https://med.noridianmedicare.com/documents/2230703/7218263/Nebulizers/ db04b968-5cd0-4445-9707-0fe51d34ec80

PMDS

Extension of Payment Change for Group 3 Complex Rehabilitative Power Wheelchairs Accessories and Seat and Back Cushions under Section 16005 of the 21st Century Cures Act

MLN Matters® Number: MM9966
Related Change Request (CR) #: CR 9966
Related CR Release Date: February 3, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3713CP
Implementation Date: April 3, 2017 - For VMS; July 3, 2017 - For FISS

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for rehabilitative power wheelchairs, accessories and seat and back cushions paid under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

What You Need to Know

Change Request (CR) 9966 highlights Section 16005 of the 21st Century Cures Act. Section 16005 modifies Section 2(a) of the Patient Access and Medicare Protection Act (PAMPA) to require that the adjusted fee schedule amounts for 2017, described in Section 1834(a)(1)(F)(ii) of the Social Security Act, are not to be applied to wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (described by HCPCS codes K0848 through K0864) prior to July 1, 2017.

- The codes for wheelchair accessories and seat and back cushions affected by the date extension change to July 1, 2017, are listed in Attachment A in CR9966 and also included in this article. Suppliers must use the KU modifier with the codes denoted in the attachment for claims submitted on or after January 1, 2017, for dates of service on or after January 1, 2017, and before July 1, 2017.
- The KU modifier and the unadjusted fee schedule amounts mandated for use in paying 2017 claims for these items are added to the January 2017 DMEPOS fee schedule file for the codes listed in Attachment A.
- The unadjusted 2016 KU fee schedule amounts were updated by the 0.7 percent 2017 covered item update.

Background

Transmittal 3671 dated December 5, 2016 (MLN Matters Article MM9854) provided instructions regarding the 2017 annual update for the DMPEOS fee schedule. Legislation effective January 1, 2017, requires changes to the 2017 fee schedule amounts for certain items. CR 9966 provides instructions regarding the implementation of the 2017 fee schedule amounts based on the changes mandated by Section 16005 of the 21st Century Cures Act.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain DME items furnished on or after January 1, 2016, including wheelchair accessories and seat and back cushions in areas that are not competitive bid areas, based on information from competitive bidding programs for DME. However, Section 2 of the PAMPA requires that the adjusted fee schedule amounts for 2016 not be applied to wheelchair accessories (including seating systems) and seat and back cushions when furnished in connection with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017.

CR9520 (Transmittal 3535, dated June 7, 2016 CR9520) and CR9586 (Transmittal 1671, dated June 2, 2016 CR9586) implemented this PAMPA provision and required the use of the KU modifier (DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3) to pay claims for dates of service on or after January 1, 2016, and before January 1, 2017.

The KU modifier and fee schedule amounts mandated for use in paying 2016 claims for wheelchair accessory or seat or back cushion when furnished in connection with a Group 3 complex rehabilitative power wheelchair were added to the 2016 DMEPOS fee schedule file. In accordance with the PAMPA provision, the KU fees were deleted from the DMEPOS fee schedule file effective January 1, 2017.

Key Points

- Beginning January 1, 2017, through June 30, 2017, the 2017 unadjusted fee schedule amounts for the codes listed in Attachment A and associated with the KU modifier are included in the DMEPOS fee schedule file.
- Your MAC will process claims associated with the HCPCS codes that are eligible to use the KU modifier by applying the effective dates in a user controlled table so that the utilization of the KU modifier can be extended beyond the current end date of December 31, 2016.
- Your MAC will process claims using the 2017 unadjusted fee amounts for claims with the applicable HCPCS code, submitted with the "KU" modifier, for claims with dates of service between January 1, 2017 and prior to July 1, 2017.

Attachment A

HCPCS	Short Descriptor	HCPCS	Short Descriptor
E0705	Transfer device	E2386	Foam filled drive wheel tire
E0950	Tray	E2387	Foam filled caster tire
E0951	Loop heel	E2388	Foam drive wheel tire
E0952	Toe loop/holder, each	E2389	Foam caster tire
E0955	Cushioned headrest	E2390	Solid drive wheel tire
E0956	W/c lateral trunk/hip suppor	E2391	Solid caster tire
E0957	W/c medial thigh support	E2392	Solid caster tire, integrate
E0960	W/c shoulder harness/straps	E2394	Drive wheel excludes tire
E0973	W/Ch access det adj armrest	E2395	Caster wheel excludes tire
E0978	W/C acc,saf belt pelv strap	E2396	Caster fork
E0981	Seat upholstery, replacement	E2397	Pwc acc, lith-based battery
E0982	Back upholstery, replacement	E2601	Gen w/c cushion wdth < 22 in
E0985	W/c seat lift mechanism	E2602	Gen w/c cushion wdth >=22 in
E0990	Wheelchair elevating leg res	E2603	Skin protect wc cus wd <22in
E0995	Wheelchair calf rest	E2604	Skin protect wc cus wd>=22in

HCPCS	Short Descriptor	HCPCS	Short Descriptor
E1002	Pwr seat tilt	E2605	Position wc cush wdth <22 in
E1003	Pwr seat recline	E2606	Position wc cush wdth>=22 in
E1004	Pwr seat recline mech	E2607	Skin pro/pos wc cus wd <22in
E1005	Pwr seat recline pwr	E2608	Skin pro/pos wc cus wd>=22in
E1006	Pwr seat combo w/o shear	E2611	Gen use back cush wdth <22in
E1007	Pwr seat combo w/shear	E2612	Gen use back cush wdth>=22in
E1008	Pwr seat combo pwr shear	E2613	Position back cush wd <22in
E1010	Add pwr leg elevation	E2614	Position back cush wd>=22in
E1012	Ctr mount pwr elev leg rest	E2615	Pos back post/lat wdth <22in
E1016	Shock absorber for power w/c	E2616	Pos back post/lat wdth>=22in
E1020	Residual limb support system	E2619	Replace cover w/c seat cush
E1028	W/c manual swingaway	E2620	WC planar back cush wd <22in
E1029	W/c vent tray fixed	E2621	WC planar back cush wd>=22in
E1030	W/c vent tray gimbaled	E2622	Adj skin pro w/c cus wd<22in
E2207	Crutch and cane holder	E2623	Adj skin pro wc cus wd>=22in
E2208	Cylinder tank carrier	E2624	Adj skin pro/pos cus<22in
E2209	Arm trough each	E2625	Adj skin pro/pos wc cus>=22
E2210	Wheelchair bearings	E2626	Seo mobile arm sup att to wc
E2310	Electro connect btw control	E2627	Arm supp att to wc rancho ty
E2311	Electro connect btw 2 sys	E2628	Mobile arm supports reclinin
E2321	Hand interface joystick	E2629	Friction dampening arm supp
E2322	Mult mech switches	E2630	Monosuspension arm/hand supp
E2323	Special joystick handle	E2631	Elevat proximal arm support
E2324	Chin cup interface	E2632	Offset/lat rocker arm w/ela
E2325	Sip and puff interface	E2633	Mobile arm support supinator
E2326	Breath tube kit	K0015	Detach non-adjus hght armrst
E2327	Head control interface mech	K0017	Detach adjust armrest base
E2328	Head/extremity control inter	K0018	Detach adjust armrst upper
E2329	Head control nonproportional	K0019	Arm pad each
E2330	Head control proximity switc	K0020	Fixed adjust armrest pair
E2351	Electronic SGD interface	K0037	High mount flip-up footrest
E2359	Gr34 sealed leadacid battery	K0038	Leg strap each
E2360	22nf nonsealed leadacid	K0039	Leg strap h style each
E2361	22nf sealed leadacid battery	K0040	Adjustable angle footplate
E2362	Gr24 nonsealed leadacid	K0041	Large size footplate each
E2363	Gr24 sealed leadacid battery	K0042	Standard size footplate each
E2364	U1nonsealed leadacid battery	K0043	Ftrst lower extension tube
E2365	U1 sealed leadacid battery	K0044	Ftrst upper hanger bracket
E2366	Battery charger, single mode	K0045	Footrest complete assembly
E2367	Battery charger, dual mode	K0046	Elevat legrst low extension
E2368	Power wc motor replacement	K0047	Elevat legrst up hangr brack
E2369	Pwr wc drivewheel gear repl	K0051	Cam relese assem ftrst/lgrst

PMDS

HCPCS	Short Descriptor	HCPCS	Short Descriptor
E2370	Pwr wc motor/gear box combo	K0052	Swingaway detach footrest
E2371	Gr27 sealed leadacid battery	K0053	Elevate footrest articulate
E2373	Hand/chin ctrl spec joystick	K0056	Seat ht <17 or >=21 ltwt wc
E2374	Hand/chin ctrl std joystick	K0065	Spoke protectors
E2375	Non-expandable controller	K0069	Rear whl complete solid tire
E2376	Expandable controller, repl	K0070	Rear whl compl pneum tire
E2377	Expandable controller, initl	K0071	Front castr compl pneum tire
E2378	Pw actuator replacement	K0072	Frnt cstr cmpl sem-pneum tir
E2381	Pneum drive wheel tire	K0073	Caster pin lock each
E2382	Tube, pneum wheel drive tire	K0077	Front caster assem complete
E2383	Insert, pneum wheel drive	K0098	Drive belt power wheelchair
E2384	Pneumatic caster tire	K0105	Iv hanger
E2385	Tube, pneumatic caster tire	K0733	12-24hr sealed lead acid

Additional Information

The official instruction, CR9966, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3713CP.pdf.

REIMBURSEMENT

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

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - July 2016

MLN Matters® Number: MM9612
Related Change Request (CR) #: CR 9612
Related CR Release Date: April 22, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3494CP
Implementation Date: July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9612 informs MACs to download and implement the July 2016 Average Sales Price (ASP) drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the April 2016, January 2016, October 2016 and July 2015, 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 5, 2016, with dates of service July 1, 2016, through September 30, 2016. Make sure that your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs 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 that can be located in the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER)).

The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
July 2016 ASP and ASP NOC	July 1, 2016, through September 30, 2016
April 2016 ASP and ASP NOC	April 1, 2016, through June 30, 2016
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015
July 2015 ASP and ASP NOC	July 1, 2015, through September 30, 2015

Additional Information

The official instruction, CR 9612 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3494CP.pdf.

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - October 2016

MLN Matters® Number: MM9724
Related Change Request (CR) #: CR 9724
Related CR Release Date: July 29, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3573CP
Implementation October 3, 2016

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

Change Request (CR) 9724 provides the October 2016 quarterly update and instructs MACs to download and implement the October 2016 Average Sales Price (ASP) drug pricing files and, if released by CMS, the July 2016, April 2016, January 2016, and October 2015, 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 October 3, 2016, with dates of service October 1, 2016, through December 31, 2016. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers. CMS will supply MACs 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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the "Medicare Claims Processing Manual" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
October 2016 ASP and ASP NOC	October 1, 2016, through December 31, 2016
July 2016 ASP and ASP NOC	July 1, 2016, through September 30, 2016
April 2016 ASP and ASP NOC	April 1, 2016, through June 30, 2016
January 2016 ASP and ASP NOC	January 1, 2016, through March 31, 2016
October 2015 ASP and ASP NOC	October 1, 2015, through December 31, 2015

Additional Information

The official instruction, CR9724, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3573CP.pdf.

HCPCS Codes Used for Home Health Consolidated Billing Enforcement – Annual Update – Revised

MLN Matters® Number: MM9771 Revised
Related Change Request (CR) #: CR 9771
Related CR Release Date: October 7, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3618CP
Implementation Date: January 3, 2017

This article was revised on January 12, 2017, to correct in the table on page 2. The table incorrectly listed HCPCS code 97177. The correct HCPCS code is HCPCS 97167 (OT EVAL HIGH COMPLEX 60 MIN). All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for Home Health Agencies (HHAs) and other providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries in a home health period of coverage.

Provider Action Needed

Change Request (CR) 9771 provides the 2017 annual update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

With the exception of therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (that is, under a home health plan of care administered by a home health agency). Medicare will only directly reimburse the primary home health agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (for example, K codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates; that is, new updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Section 1842(b)(6) of the Social Security Act requires that payment for home health services provided under a home health plan of care is made to the home health agency.

The HCPCS codes in the table below are being added to the HH consolidated billing therapy code list, effective for services on or after January 1, 2017. These codes replace HCPCS codes: 97001, 97002, 97003, 97004.

HCPCS Code	Descriptor
97161	PT EVAL LOW COMPLEX 20 MIN
97162	PT EVAL MOD COMPLEX 30 MIN
97163	PT EVAL HIGH COMPLEX 45 MIN
97164	PT RE-EVAL EST PLAN CARE
97165	OT EVAL LOW COMPLEX 30 MIN
97166	OT EVAL MOD COMPLEX 45 MIN
97167	OT EVAL HIGH COMPLEX 60 MIN
97168	OT RE-EVAL EST PLAN CARE

G0279 and G0280 are deleted from the HH consolidated billing therapy code list. These codes were replaced with 0019T and should have been removed from the list in earlier updates. Effective January 1, 2015, these codes were redefined for another purpose. MACs will adjust claims denied due to HH consolidated billing with HCPCS codes G0279 and G0280 and line item dates of service on or after January 1, 2015, if brought to their attention.

Additional Information

The official instruction, CR 9771 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3618CP.pdf.

DMEPOS Fee Schedule – 2017 Update

MLN Matters® Number: MM9854
Related Change Request (CR) #: CR 9854
Related CR Release Date: December 5, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3671CP
Implementation Date: January 3, 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) 9854 provides the calendar year (CY) 2017 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in Chapter 23 Section 60 in the "Medicare Claims Processing Manual."

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

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 Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs. The methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs are established in regulations at 42 CFR Section 414.210(g). Also, program instructions on these changes are available in Transmittal 3551, CR 9642 (MLN Matters article MM9642), dated June 23, 2016, and Transmittal 3416, CR 9431 (MM9431), dated November 23, 2015.

The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated pursuant to 42 CFR 414.210(g)(8) when information from the CBPs is updated. This update to the adjusted fees includes information from the CBPs that takes effect on January 1, 2017 (Round 1 2017). Pursuant to 42 CFR Section 414.210(g)(4), for items where the single payment amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2017 for this update) and for each subsequent year such as 2018 and 2019.

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. Regulations at Section 414.202 define rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

Policy: Fee Schedule and Rural Zip Code Files

The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for both enteral nutrition items and national non-rural fee schedule amounts for parenteral nutrition items.

The DMEPOS and PEN fee schedules and the rural ZIP code public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties on the CMS DMEPOS fee schedule website after November 18, 2016.

New Codes Added

The new codes are not to be used for billing purposes until they are effective on January 1, 2017. For

gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2016 by payment category are in the table below.

0.454 for Oxygen	0.457 for Capped Rental	0.458 for Prosthetics and Orthotics
0.582 for Surgical Dressings	0.633 for Parental and Enteral Nutrition	0.969 for Splints and Casts
0.952 for Intraocular Lenses		

Codes Deleted

Codes deleted from the DMEPOS fee schedule files effective January 1, 2017, are:

- B9000 - Enteral nutrition infusion pump - without alarm (Enter infusion pump w/o alrm)
- B9000MS - Enteral nutrition infusion pump - without alarm
- E0628 - Separate seat lift mechanism for use with patient owned furniture-electric (Seat lift for pt furn-electr)
- K0901 - Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Ko single upright pre ots)
- K0902 - Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Ko double upright pre ots)

Effective January 1, 2017, codes B9000 and E0628 will crosswalk to codes B9002 and E0627 respectively. Payment for necessary maintenance and servicing of B9000 pumps will also crosswalk to B9002MS.

Effective January 1, 2017, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are deleted from the DMEPOS fee schedule file.

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. The list of HCPCS codes to which this statutory section applied is available in Transmittal 3535, CR 9520 Transmittal 3535, CR 9520, dated June 7, 2016.

Specific Coding and Pricing Issues

Effective January 1, 2017, existing off-the-shelf orthotic (OTS) codes K0901 and K0902 are re-designated as codes L1851 and L1852 respectively. The fee schedule amounts for codes K0901 and K0902 will be applied to the corresponding new codes L1851 and L1852 as part of this update. Attachment B in CR 9854 updates the list of orthotic codes that are designated as OTS on the CMS orthotics website to reflect the addition of the two renumbered codes (L1851 and L1852).

As part of the this update, the adjusted fee schedule amounts for the following groups of similar items are adjusted in accordance with 42 CFR Section 414.210 (g)(6) to limit the single payment amounts (SPAs) for items without certain features to the weighted average of the SPAs for the items both with and without the features prior to using the SPAs in adjusting the fee schedule amounts:

1. Hospital beds (HCPCS codes E0250, E0251, E0255, E0256, E0260, E0261, E0290, E0291, E0292, E0293, E0294, E0295, E0301, E0302, E0303 and E0304)
2. Mattress and overlays (HCPCS codes E0277, E0371, E0372, and E0373)
3. Power wheelchairs (HCPCS codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, and K0823)
4. Seat lift mechanisms (HCPCS codes E0627and E0629)
5. TENS devices (HCPCS codes E0720 and E0730)
6. Walkers (HCPCS codes E0130, E0135, E0141 and E0143)

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act

required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513).

To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004.

For 2017, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2015. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2017.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are re-competed. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. The program instructions reviewing these changes are Transmittal 2709, CR 8325 (MM8325), dated May 17, 2013, and Transmittal 2661, CR 8204 (MM8204), dated February 22, 2013. Note that the mail order DTS (KL) fee schedule amounts for all states and territories were removed from the DMEPOS fee schedule file as part of the July 1, 2016, update.

2017 Fee Schedule Update Factor of 0.7 Percent

For CY 2017, an update factor of 0.7 percent is applied to certain DMEPOS fee schedule amounts.

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2017 by the percentage increase in the consumer price index for all urban consumers (United States city average) or urban consumers (CPI- U) for the 12-month period ending with June of 2016, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). The MFP adjustment is 0.3 percent and the CPI-U percentage increase is 1 percent. Therefore, the 1 percentage increase in the CPI-U is reduced by the 0.3 percentage increase in the MFP resulting in a net increase of 0.7 percent for the update factor.

2017 Update to the Labor Payment Rates

Included below and in Attachment A in CR9854 are the CY 2017 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI- U for the twelve month period ending with June 30, 2016, is 1 percent, this change is applied to the 2016 labor payment amounts to update the rates for CY 2017. The 2017 labor payment amounts in Attachment A are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2017, through December 31, 2017.

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
AK	$28.29	$32.23	$37.92	**NC**	$15.02	$22.38	$30.38
AL	$15.02	$22.38	$30.38	**ND**	$18.72	$32.16	$37.92
AR	$15.02	$22.38	$30.38	**NE**	$15.02	$22.35	$42.36
AZ	$18.57	$22.35	$37.38	**NH**	$16.13	$22.35	$30.38
CA	$23.04	$36.74	$42.81	**NJ**	$20.26	$22.35	$30.38
CO	$15.02	$22.38	$30.38	**NM**	$15.02	$22.38	$30.38
CT	$25.08	$22.88	$30.38	**NV**	$23.93	$22.35	$41.41

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
DC	$15.02	$22.35	$30.38	NY	$27.65	$22.38	$30.38
DE	$27.65	$22.35	$30.38	OH	$15.02	$22.35	$30.38
FL	$15.02	$22.38	$30.38	OK	$15.02	$22.38	$30.38
GA	$15.02	$22.38	$30.38	GA	$15.02	$22.38	$30.38
HI	$18.57	$32.23	$37.92	HI	$18.57	$32.23	$37.92
IA	$15.02	$22.35	$36.37	IA	$15.02	$22.35	$36.37
ID	$15.02	$22.35	$30.38	ID	$15.02	$22.35	$30.38
IL	$15.02	$22.35	$30.38	IL	$15.02	$22.35	$30.38
IN	$15.02	$22.35	$30.38	IN	$15.02	$22.35	$30.38
KS	$15.02	$22.35	$37.92	KS	$15.02	$22.35	$37.92
KY	$15.02	$28.65	$38.85	KY	$15.02	$28.65	$38.85
LA	$15.02	$22.38	$30.38	LA	$15.02	$22.38	$30.38
MA	$25.08	$22.35	$30.38	MA	$25.08	$22.35	$30.38
MD	$15.02	$22.35	$30.38	MD	$15.02	$22.35	$30.38
ME	$25.08	$22.35	$30.38	ME	$25.08	$22.35	$30.38
MI	$15.02	$22.35	$30.38	MI	$15.02	$22.35	$30.38
MN	$15.02	$22.35	$30.38	MN	$15.02	$22.35	$30.38
MO	$15.02	$22.35	$30.38	MO	$15.02	$22.35	$30.38
MS	$15.02	$22.38	$30.38	MS	$15.02	$22.38	$30.38
MT	$15.02	$22.35	$37.92				

2017 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

As part of this update, CMS is implementing the 2017 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2017, through December 31, 2017. As required by statute, the addition of the separate payment classes for oxygen generating portable equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral. Medicare expenditures must account for these separate oxygen payment classes. Therefore, the fee schedule amounts for stationary oxygen equipment are reduced by a certain percentage each year to balance the increase in payments made for the additional separate oxygen payment classes. For dates of service January 1, 2017, through December 31, 2017, the 2017 monthly fee schedule payment amounts for stationary oxygen equipment range from approximately $67 to $77, incorporating the budget neutrality adjustment factor.

When updating the stationary oxygen equipment amounts, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the payment amounts for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2017 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2017 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6972 (MM6972), dated February 5, 2010 and Transmittal 717, CR6990 (MM6990), dated June 8, 2010. To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months, beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for HCPCS codes E1390, E1391, E0433 or K0738, billed with the MS modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Therefore, the 2016 maintenance and servicing fee is adjusted by the 0.7 percent MFP-adjusted covered item update factor to yield CY 2017 maintenance and servicing fee of $69.97 for oxygen concentrators and transfilling equipment.

Additional Information

The official instruction, CR 9854 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3671CP.pdf on the CMS website.

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM9878
Related Change Request (CR) #: CR 9878
Related CR Release Date: February 24, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R3725CP
Implementation Date: July 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9878 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists. CR9878 also calls for an update to Medicare Remit Easy Print (MREP) and PC Print software. If you use MREP and/or PC Print software, be sure to obtain the latest version that is released on or before July 3, 2017. Make sure that your billing staffs are aware of these changes.

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, that 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 is published three times per year – around March 1, July 1, and November 1.

CR9878 provides notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's Shared System Maintainers (SSMs) have the responsibility to implement code deactivation, 1) making sure that any deactivated code is not used in original business messages, and 2) 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 CR9878, MACs must implement on the date specified on the WPC website.

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 CR9878, MACs and SSMs must determine the changes that are included on the code list since the last code update CR (CR 9774) or its corresponding MM Article (MM9774).

Additional Information

The official instruction, CR9878, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3725CP.pdf.

DMEPOS HCPCS Code Jurisdiction List 2017 – Revised

MLN Matters® Number: MM9903 Revised
Related Change Request (CR) #: CR 9903
Related CR Release Date: January 5, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3689CP
Implementation Date: January 24, 2017

This article was revised on January 6, 2017, to reflect the revised CR9903 issued on January 5. 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 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) 9903 notifies suppliers that the spreadsheet containing the jurisdiction list of Healthcare Common Procedure Coding System (HCPCS) codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the "Medicare Claims Processing Manual" are reflected in the recurring update notification. The document for the 2017 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html and is also attached CR9903.

Additional Information

The official instruction, CR9903, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3689CP.pdf.

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - April 2017

MLN Matters® Number: MM9945
Related Change Request (CR) #: CR 9945
Related CR Release Date: January 13, 2017
Effective Date: April 1, 2017
Related CR Transmittal #: R3692CP
Implementation Date: April 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

Change Request (CR) 9945 provides the April 2017 quarterly update and instructs MACs to download and implement the April 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised January 2017, October 2016, July 2016, and April 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 April 3, 2017, with dates of service April 1, 2017, through June 30, 2017. MACs will not search and adjust claims previously processed unless brought to their attention.

For claims with a date of service on or after January 1, 2017, and consistent with Section 5004 of the 21st Century Cures Act, which was signed into law on December 13, 2016, payment for infusion drugs furnished through a covered item of Durable Medical Equipment (DME) will be based on Section 1847A of the Social Security Act, meaning that most of the payments will be based on the ASP of these drugs. Payment for DME infusion drugs that do not appear on the ASP Drug Pricing Files will be determined by the MACs in accordance with 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. Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs 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 Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions that are in Chapter 4, Section 50 of the "Medicare Claims Processing Manual" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

The following table shows how the quarterly payment files will be applied

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

Additional Information

The official instruction, CR9945, issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3692CP.pdf**.

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