DME Happenings

Jurisdiction D

September 2017

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Phone Numbers		
Interactive Voice Response System	1-866-419-9458	24/7 for Eligibility 8 a.m. – 5 p.m. for all other inquiries
Supplier Contact Center	1-866-419-9458	8 am – 5 pm ET Monday-Friday
Telephone Reopenings	1-866-419-9458	8 am – 5 pm ET
Beneficiary Customer Service	1-800-633-4227	24/7
Fax Numbers		
Reopenings/Redeterminations Recovery Auditor Redeterminations		701-277-2425
Recoupment • Refunds to Medicare • Immediate Offsets		701-277-2427
MSP Refunds		701-277-7892
Recovery Auditor Offsets		701-277-7896
MR Medical Documentation		701-277-2426
Email Addresses/Websites		
NHS DME Customer Service	https://med.noridianmedicare.com/web/jadme/contact/email-customer-service	
Reopenings and Redeterminations	dmeredeterminations@noridian.com	
Noridian JA Website	https://med.noridianmedicare.com/web/jadme	
Mailing Addresses		
• Claims • Redetermination Requests • Correspondence • ADMC Requests • Medical Review Documentation • Recovery Auditor Overpayments		**Noridian JA DME** Attn: _____ PO Box 6780 Fargo, ND 58108-6780
• Benefit Protection • Administrative Simplification Compliance Act Exception Requests (ASCA)		**Noridian JA DME** Attn: _____ PO Box 6736 Fargo, ND 58108-6736
Qualified Independent Contractor (QIC)		**C2C Solutions, Inc.** Attn: DME QIC PO Box 44013 Jacksonville, FL 32231-4013
• EFT Forms • Overpayment Redeterminations • Recovery Auditor Redeterminations		**Noridian JA DME** Attn: _____ PO Box 6728 Fargo, ND 58108-6728

Other DME MACs and Other Resources		
Noridian: Jurisdiction D	877-320-0390	https://med.noridianmedicare.com/web/jddme
CGS: Jurisdiction B	877-299-7900	www.cgsmedicare.com
CGS: Jurisdiction C	866-238-9650	www.cgsmedicare.com
Pricing, Data Analysis and Coding (PDAC)	877-735-1326	www.dmepdac.com
National Supplier Clearinghouse	866-238-9652	www.palmettogba.com/nsc
Common Electronic Data Interchange (CEDI) Help Desk	866-311-9184	www.ngscedi.com
Centers for Medicare and Medicaid Services (CMS)		www.cms.gov

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

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.

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.

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

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

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

CR9968 Fee Schedule Adjustments - Claim Processing Education

Noridian would like to make suppliers aware of two claims processing items for the CR9968 21st Century Cures Act Fee Schedule Adjustments.

1. Suppliers with oxygen claims covered under these mass adjustments may see miscellaneous code E1399cc on some remittances. Due to system limitations, the code E1399 is being used when previous oxygen CMNs have been deleted and are no longer on file due to a new CMN superseding the previous CMN. Code E1399 was used since it will not impact current or future oxygen claims. The cc modifier also signifies that the HCPCS was changed during processing.

2. Noridian will not be adjusting rented Inexpensive and Routinely Purchased (IRP) items when the first rental month occurred before July 1, 2016. For rented IRP items, Medicare pays rentals up to the purchase price. Since the purchase price is established by the date of service from the first rental month, the purchase price will not change due to these adjustments, as the initial (first rental month) date of service does not fall into the timeframe for these adjustments, 7/1/2016-12/31/2016.

DME Supplier Participation and Assignment Reminders

Noridian and CGS Outreach and Education teams have collaborated to provide information to the supplier community regarding DME Medicare participation status and requirements for accepting assignment on DMEPOS claims. This article, in the form of a Q & A document, addresses many of the questions received by the DME MACs over the past months.

Question: What does "participating supplier" mean?

Answer: A participating supplier is one that agrees to accept assignment for all services furnished to Medicare beneficiaries during a 12-month period, beginning January 1 of each year. By completing the CMS-460 Participating Physician or Supplier Agreement Form each year, the supplier accepts the Medicare allowed amount as payment in full. The supplier can collect the twenty percent coinsurance, any unmet deductible and payment for statutorily non-covered services from the beneficiary at the time of the service. By accepting assignment, the reimbursement is sent to the supplier.

Question: What is the CMS-460 Participating Physician or Supplier Agreement Form?

Answer: The CMS-460 Participating Physician or Supplier Agreement Form is the form submitted to the National Supplier Clearinghouse (NSC) that, when completed, verifies the supplier is now "participating." This must be done within 90 days of initial enrollment as a new DME supplier, or during the annual open enrollment period, which is typically mid-November through December 31 of each year. The CMS-460 form must be signed by the authorized or delegated official on file with the NSC. This participation agreement is valid for the balance of the calendar year and will renew automatically beginning January 1 of each calendar year.

Note: The participation status is associated with the tax ID for the organization and not the individual location. If a supplier has multiple locations under the same tax ID, the participation status for each location must remain the same. This also holds true for hospital-based DME companies. If the hospital-based DME is under the same tax ID as the hospital, and the hospital is participating, then the DME supplier must also be participating.

Question: Are there any advantages to being a participating supplier?

Answer: Per CMS, participation improves relationships with beneficiaries because it reduces their out-of-pocket expenses. Medicare designates participating suppliers from non-participating suppliers on the http://www.medicare.gov/ Supplier Directory and this may contribute to a beneficiary's supplier election. Medicare also offers a benefit to participating suppliers to expedite claim processing with select Medigap plans that do not accept electronic crossover files. DME MACs will send a paper claim equivalent to these Medigap plans on behalf of participating suppliers only. Non-participating suppliers must file their own paper claims when the plans do not accept electronic crossover files.

Question: What should the supplier do if they no longer want to remain a participating supplier?

Answer: If the supplier is currently a participating supplier and wishes to change their status to a non-participating supplier for the next calendar year, they will need to submit a written request to the NSC.

This request must be on company letterhead, contain the organization's tax ID and be signed by the authorized or delegated official on file with the NSC. This request must be sent to the NSC by December 31 of the current year in order for it to take effect for the following calendar year.

Question: What does "accept assignment" mean?

Answer: An assignment agreement is between a supplier of services and a Medicare beneficiary. The option of accepting assignment belongs solely to the supplier. Participating suppliers have signed a contract with Medicare agreeing to accept assignment on all services rendered to Medicare beneficiaries. Non-participating suppliers have the option of accepting assignment on a claim-by-claim basis except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, competitive bidding contracts, etc.).

Once an assignment agreement is made, it may not be rescinded by non-participating suppliers unless done so by mutual written agreement of the supplier and beneficiary. This agreement must be communicated to the DME MAC (Item 27 on the CMS-1500 form) before the DME MAC has made, and sent notice of, the claim determination. Participating suppliers may not rescind the assignment agreement during the period of their participation contract.

When a supplier accepts assignment, they are bound by law to accept the DME MAC's determination of the approved amount as payment in full for the service rendered. The supplier must attempt to collect (1) twenty percent of the approved amount (coinsurance), (2) any amount applied to the deductible and (3) any items deemed to be noncovered (subject to the Limitation of Liability provisions).

Question: Can a non-participating supplier change the assignment on a claim-by-claim basis?

Answer: A non-participating supplier may choose to bill the claim as "assigned" on a claim-by-claim basis with a few exceptions. Section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) states that all drugs and biologicals must be billed as assigned. Bid winning suppliers in competitive bid areas must accept assignment on all equipment category claims where a competitive bid contract is held. Noncontract suppliers must accept assignment on all competitive bid items (i.e., claims for traveling beneficiaries or grandfathered items). Medicare also requires claim assignment for all dual eligible QMB beneficiaries (beneficiaries entitled to benefits from both Medicare and Medicaid). Please refer to MLN Matters 9911 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9911.pdf) for additional information on Qualified Medicare Beneficiaries (QMBs).

Question: Is there a limit on how much a supplier can charge on nonassigned claims?

Answer: The "limiting charge" does not apply to DMEPOS items because they are not paid under the Physician Fee Schedule where the "limiting charge" concept is applicable. The assignment decision only binds the supplier to the DME fee schedule as payment in full; it does not impact in any way the usual and customary billed amounts that a supplier submits on their claim. The supplier should have consistent, usual and customary charges that are billed to retail and non-retail customers. In a nonassigned claim transaction, the supplier will collect its usual and customary charge (and will not be bound to the Medicare DMEPOS Fee Schedule). Medicare cannot issue any guidance on usual or customary charges.

For nonassigned claims, Medicare will remit payment (based on the Medicare fee schedule) directly to the beneficiary. Because payments will be made to the beneficiary and not to the supplier, a supplier who chooses not to accept assignment of Medicare benefits is not considered a party to the claim.

Question: Does a supplier need to get a beneficiary authorization signed for each claim?

Answer: Chapter 1, Section 50.1.6 of the Medicare Claims Processing Manual (IOM 100-4) (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf) outlines the relevant guidance on beneficiary authorizations. Once the supplier has obtained the beneficiary's one-time authorization; later claims for those same services, either assigned or nonassigned, can be filed without obtaining an additional signature from the beneficiary. Any supplier using the one-time authorization procedure agrees to the following:

- Authorization must be renewed if a new item is rented or purchased.
- Retaining the signed and dated one-time payment authorization form in the supplier's file.

The one-time authorization applies to assigned and nonassigned claims with the exception of DME rentals. The one-time authorization for DME rental claims is limited to assigned claims. For nonassigned DME rentals, the supplier must get a beneficiary authorization signed prior to billing each rental claim. Without a specific authorization, the supplier would be unable to bill the rental claim to the Fee-For-Service Medicare program.

Question: Must suppliers always accept assignment on dually eligible beneficiaries (Medicare and Medicaid)?

Answer: Suppliers are not required to accept assignment, however they are prohibited from billing the beneficiary for any outstanding balances after all Medicare and Medicaid payments have been made. Please refer to the question noted above concerning QMB beneficiaries.

Question: Can all claims, whether billed as assigned or nonassigned, be audited?

Answer: Yes. Claim assignment has no bearing on audits. Pre-payment and post-payment audits can occur for any claim, regardless of whether it was originally billed as assigned or nonassigned.

Question: What are the documentation requirements for nonassigned claims?

Answer: The Medicare documentation requirements to support DMEPOS claims are the same regardless of whether a claim is submitted as assigned or nonassigned. If a nonassigned claim is stopped for review (either pre-payment or post-payment) the supplier is responsible for responding to the auditing entity and providing supporting documentation per the request (which may include detailed written orders, relevant medical records, delivery documents, etc.). In addition, a nonassigned claim may be denied as Contractual Obligation and the supplier held responsible for the payment or reimbursement to the beneficiary.

Chapter 30 of the Medicare Claims Processing Manual (IOM 100-4) addresses Financial Liability Protections and especially relevant guidance for limitation on liability, refund requirement provisions and the applicability of Advance Beneficiary Notices on these transactions. For a nonassigned claim with a CO denial, the supplier must refund any monies collected from the beneficiary until a favorable determination is made. If a supplier expects Medicare to deny the claim, or has reason to believe the service is not medically necessary, specific concerns must be articulated in writing via an Advance Beneficiary Notice (ABN) prior to delivering product. This document is equally applicable to assigned and nonassigned claims.

Advance Beneficiary Notice of Noncoverage Form – Reminder

Effective June 21, 2017, suppliers should only be using the current version of the Advance Beneficiary Notice of Noncoverage (ABN) form, the previous version is no longer valid. The current version of the ABN form has an expiration date of 03/2020.

The current version and instructions are available in the ABN section of the Forms page.

CR9968 CURES Act Fee Schedule Adjustments FAQs – Updated

The CR9968 CURES Act Fee Schedule Adjustments Frequently Asked Questions (FAQs) have been updated.

View the complete FAQs on the CR9968 CURES Act Fee Schedule Adjustments webpage.

Customized Education to Fit Your Schedule

Did you miss a webinar or have questions but don't want to ask them during a webinar? Do you have referral sources that could benefit from ordering DMEPOS training? Noridian is offering free individual supplier education customized to fit your needs and schedule.

Electronic Supplier Visits (E-visit) are conducted using GoToMeeting where participants will view a presentation specifically designed to address your questions and concerns and speak directly to a Noridian Education and Outreach representative.

Complete an E-visit Request Form and a Noridian Outreach and Education representative will contact you to schedule an E-visit tailored to your requests. Referral sources are encouraged to attend to learn directly from Noridian on supplier requirements.

Immediate Offset Request Process Change – Effective September 1, 2017

Effective September 1, 2017, DME MSP/Recoupment will no longer accept immediate offset requests submitted through the "Overpayment Refund Form." To prepare for this change, the Immediate Offset option will be removed from the "Overpayment Refund Form" August 1. Through this transition timeframe, an overpayment recoupment request submitted via this form for an immediate offset will be honored; however, as of September 1, suppliers who want to satisfy such requests must do so by following one of the below options.

- Submit a completed "Request for Immediate Recoupment Form" when the initial Demand Letter is received. Request to have that debt and/or all future debts satisfied through an Immediate Offset.
- Send the overpayment monies, in the form of a check, with the completed "Overpayment Refund Form" to the address indicated on the form.

Access these forms from the Refunds/Overpayments Forms webpage.

KE Modifier Adjustments to the Fully Adjusted Payment Rates for 21st Century Cures Act

Noridian is ready to accept KE reopenings for claims with dates of service July 1, 2016 through December 31, 2016 for finalized claims. As part of the fee schedule update for the 21st Century Cures Act, the KE modifier was added to the fee schedule for use on items bid under the initial Round 1 of Competitive Bidding but used with non-competitive bid base equipment.

For information on how to submit these reopenings, see the KE Modifier Reopenings section on the CR9968 Cures Act Fee Schedule Adjustments web page.

RT and LT Modifiers on the Same Claim Line for Capped Rental Items - Update

Effective July 3, 2017, the Common Electronic Data Interchange (CEDI) has removed the claim editing requirement for the RT and LT modifiers to be included in the second and third position on the claim line for bilateral Capped Rental items when two units of service are billed.

This change will impact codes that need to be submitted with more than four modifiers on the same claim line. As a result of this change, the RT and LT modifier should be included in the narrative field and the applicable pricing and informational modifiers should be on the claim line.

All codes requiring more than four modifiers must list the 99 modifier in the fourth position on the claim line with all modifiers reported in the narrative field.

An example of modifiers included for a bilateral capped rental repair replacement code billed with two units are as follows:

- Claim line = NU KH KX 99
- Narrative = NU KH KX RB RT LT (and any other applicable modifiers)

Remember to continue billing with two units of service for these types of claims. For additional information, visit the following pages on the Noridian website.

- Modifiers
- Power Mobility Devices (PMDs)
- Capped Rental Items

Modifiers, PMD, power mobility, capped rental, RTLT, RT and LT, 99 modifier, power wheelchair, complex rehab

Rollator Walkers – Using HCPCS Code A9270

The DME MACs have received a number of questions about certain accessories provided with wheeled walkers, especially the "rollator" style of walker (E0143).

Many "rollator" types of walkers are manufactured with a seat for the beneficiary to use when feeling tired or unstable. According to the PDAC (Pricing, Data Analysis and Coding) Contractor, suppliers may bill two codes for this walker: the E0143 (wheeled walker) and the E0156 (seat attachment).

The related Policy Article (A52503) for Walkers states that the E0143 (wheeled walker) is coded to include glide-type brakes or equivalent. This braking system uses a spring mechanism which causes the walker leg post to release when there is no downward pressure applied to the top of the walker frame. Instead of the glide-type brakes, many "rollator" walkers have a hand braking system that is similar in nature to that of brakes on a bicycle. This hand braking system is considered an enhancement accessory that does not contribute to the overall function of the walker. As such, suppliers may bill for this variable braking system using HCPCS code A9270.

Other enhancement accessories, such as a basket or special color combination, may also be billed using HCPCS A9270, which will result in a Patient Responsibility (PR) denial on that particular claim line.

For reference, here is the excerpt from the related Policy Article for Walkers:

An enhancement accessory is one which does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes (other than those described in code E0147), or basket (or equivalent). Use code A9270 when an enhancement accessory of a walker
is billed.

The following is an example of the HCPCS codes a supplier might bill the Medicare program for a rollator walker with basket and hand braking system:

- E0143NUKX
- E0156NUKX
- A9270 (with a narrative in the NTE segment indicating the hand brakes)
- A9270 (with a narrative in the NTE segment indicating basket addition)

When the claim is processed, the E0143 and the E0156 will be considered for coverage while the two A9270 claim lines will deny PR and the beneficiary will be responsible for payment.

Please note: the preceding information should NOT be used for the E0147 walker. Suppliers are encouraged to review the related Policy Article for Walkers noted above as well as coding verification for any E0147 on the PDAC's website at www.dmepdac.com.

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

MLN Matters® Number: MM9893 Revised
Related Change Request (CR) #: CR 9893
Related CR Release Date: June 8, 2017
Effective Date: October 1, 2017
Related CR Transmittal #: R18570TN
Implementation Date: October 2, 2017

This article was revised on June 9, 2017, due to the release of an updated Change Request (CR). The CR date, transmittal number and the link to the transmittal changed. All other information remains the same.

Provider Types Affected

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

What You Need to Know

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

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

Background

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

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

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

Key Points of CR9893

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

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

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

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

- Auto/no-fault insurance set-asides diagnosis codes do not apply, or
- Liability insurance set-asides diagnosis codes do not apply, or are not related, or
- When the LMSA and NFMSA benefits are exhausted/terminated per CARC or RARC and payment information found on the incoming claim as cited in CR9009.

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

Additional Information

The official instruction, CR9893, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1857OTN.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.

Guidance on Implementing System Edits for DMEPOS – Revised

MLN Matters® Number: MM9904 Revised
Related Change Request (CR) #: CR 9904
Related CR Release Date: August 18, 2017
Effective Date: July 1, 2017
Related CR Transmittal #: R1910OTN
Implementation Date: October 2, 2017

This article was revised on August 18, 2017, to reflect an updated Change Request (CR). The CR changed the July analysis implementation date and revised the codes used for denied claims. The CR release date, transmittal number and link to the CR also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

CR9904 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.

Denied Claims

MACs will use Claim Adjustment Reason Code (CARC) B7 and Remittance Advice Remark Code (RARC) N211 and RARC N790 for denial:

- CARC B7 - This provider was not certified/eligible to be paid for thisprocedure/service on this date of service. Usage: Refer to the 835 Healthcare PolicyIdentification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N211 - Alert: You may not appeal this decision.
- RARC N790 - Provider/supplier not accredited for product/service
- Group Code: CO - Contractual Obligation

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/R1910OTN.pdf.

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

MLN Matters® Number: MM9911 Revised
Related Change Request (CR) #: CR 9911
Related CR Release Date: June 28, 2017
Effective Date: for claims processed on or after October 2, 2017
Related CR Transmittal #: R3802CP
Implementation Date: October 2, 2017

The article was revised on June 29, 2017, to reflect a revised CR9911 issued on June 28, 2017. In the article, the CR release date, transmittal number, and the Web address of CR9911 are revised. Clarifications are also made to the second paragraph of the Background section. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Background

QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. In 2015, 7.2 million persons (more than one out of every ten Medicare beneficiaries) were enrolled in the QMB program.

Federal law bars Medicare providers from billing a QMB individual for Medicare Part A and B deductibles, coinsurance, or copayments, under any circumstances. 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 payment for Medicare cost-sharing, under certain circumstances. Regardless, QMB individuals have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt related to dual eligible beneficiaries under CMS Pub. 15-1, Chapter 3 of the Provider Reimbursement Manual (PRM).

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/R3802CP.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.

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

MLN Matters® Number: MM9968 Revised
Related Change Request (CR) #: CR 9968
Related CR Release Date: June 28, 2017
Effective Date: July 1, 2016
Related CR Transmittal #: R3801CP
Implementation Date: October 2, 2017

This article was revised on June 29, 2017, to reflect the revised CR 9968 issued on June 28.As a result, the implementation date, CR release date, transmittal number, and the Web address of the CR in the article were revised. In addition, a RARC code for adjusted claims has been added. All other information remains the same.

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. MACs will use a Remittance Advice Remark Code (RARC) on the Cures Act claim adjustments for the dates of service that are being repriced in order to identify these claims. The RARC code for each of these claims is N689 - Alert: This reversal is due to a retroactive rate change.

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/R3801CP.pdf.

DMEPOS Fee Schedule – July 2017 Update – Revised

MLN Matters Number: MM10071 Revised
Related Change Request (CR) # 10071
Related CR Release Date: August 2, 2017
Effective Date: July 1, 2017
Related CR Transmittal Number: R3824CP
Implementation Date: July 3, 2017

This article was revised on August 3, 2017, to reflect an updated Change Request (CR). That CR updated the policy section on complex rehabilitative power wheelchair accessories & seat and back cushions (page 2 of this article). The CR release date, transmittal number and link to the CR was also changed. All other information is the same.

Provider Type Affected

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

Provider Action Needed

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

Background

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

Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by the Social Security Act. Section 1834 at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm.

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

Additionally, Section 1834 of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas (CBAs), based

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

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

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

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

Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs (codes K0848 through K0864) with dates of service on or after July 1, 2017. The fee schedule amounts associated with the KU modifier were not adjusted using information from the competitive bidding program in accordance with Section 2 of Patient Access and Medicare Protection Act (PAMPA) for dates of service January 1, 2016 through December 31, 2016. Section 16005 of the 21st Century Cures Act then extended the effective date through June 30, 2017. Effective for dates of service on or after July 1, 2017, taking into consideration the exclusion at section 1847(a)(2)(A) of the Social Security Act, the policy for these items is revised. As a result, payment for these items furnished in connection with a Group 3 complex rehabilitative power wheelchair and billed with the KU modifier will be based on the unadjusted fee schedule amounts updated in accordance with section 1834(a)(14) of the Act. The list of HCPCS codes associated with the KU modifier is available in Transmittal 3713, CR 9966, dated February 3, 2017. The updated DMEPOS fee schedule files have been released.

Therapeutic Continuous Glucose Monitor (CGM)

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

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

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

ADDITIONAL INFORMATION

The official instruction, CR10071, issued to your MAC regarding this change is available at

https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R3824CP.pdf.

DMEPOS CBP – October 2017 Update

MLN Matters Number: MM10128
Related Change Request (CR) Number: CR10128
Related CR Release Date: June 16, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3798CP
Implementation Date: October 2, 2017

Provider Types Affected

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

What You Need to Know

Change Request (CR) 10128 provides the October 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 CR 10128 to provide the DMEPOS Competitive Bidding Program (CBP) October 2017 quarterly update.

CR 10128 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), Zip code, and Single Payment Amount files. Note that quarterly updates are available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home. To review the updates, select (click) on the quarterly updates link on the left of the page.

Background

The DMEPOS CBP was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The 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 and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

Additional Information

The official instruction, CR10128, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3798CP.pdf.

HPTCs Code Set – October 2017 Update

MLN Matters Number: MM10141
Related Change Request (CR) # 10141
CR Release Date: August 18, 2018
Effective Date: October 1, 2017
Related CR Transmittal Number: R3842CP
Implementation Date: January 2, 2018 – Contractors with capability to do so will implement effective October 1, 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) 10141 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 comply with the requirements in the electronic transaction format implementation guides adopted as national standards. 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.

You should note that:

- Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) 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.
- Medicare would be guilty of non-compliance with HIPAA if MACs accepted claims that contain invalid HPTCs.

The HPTC set is maintained by the NUCC for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available for view from the Washington Publishing Company (WPC) website at www.wpc-edi.com/codes and can be downloaded from the NUCC's website http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40.

Although the NUCC generally posts their updates on the WPC webpage 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. The changes to the code set include the addition of a new code and addition of definitions to existing codes. When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by color code:

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

Additional Information

The official instruction, CR10141, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R3842CP.pdf.

ASP Medicare Part B Drug Pricing Files and Revisions – October 2017

MLN Matters Number: MM10187
Related Change Request (CR) Number: 10187
Related CR Release Date: July 21, 2017
Effective Date: October 1, 2017
Related CR Transmittal Number: R3809CP
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 provided to Medicare beneficiaries.

What You Need To Know

Change Request (CR) 10187 instructs MACs to download and implement the October 2017 and, if released, the revised July 2017, April 2017, January 2017, and October 2016, ASP drug pricing files for Medicare Part B drugs via the Centers for Medicare & Medicaid Services (CMS) Data Center (CDC). 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 1, 2017, with dates of service October 1, 2017, through December 31, 2017. Make sure your billing staffs are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to the CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, section 50 of the Medicare Claims Processing Manual, at https://www.cms.gov/regulations-and-Guidance/Guidance/Manuals.downloads/clm104c04.pdf.

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

For any drug or biological not listed in the ASP or NOC drug-pricing files, MACs will determine the payment allowance limits in accordance with the policy described in the "Medicare Claims Processing Manual," Chapter 17, Section 20.1.3, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf. For any drug or biological not listed in the ASP or NOC drug-pricing files that is billed with the KD modifier, contractors shall determine the payment allowance limits in accordance with instructions for pricing and payment changes for infusion drugs furnished through an item of Durable Medical Equipment (DME) on or after January 1, 2017, associated with the passage of the 21st Century Cures Act.

Additional Information

The official instruction, CR 10187, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3809cp.pdf.

Payment for Accessories used with Group 3 Complex Rehabilitative Power Wheelchairs - Effective July 1, 2017

CMS is adopting a new interpretation of the statute that impacts how adjustments to the fee schedule based on information from competitive bidding programs apply to wheelchair accessories used with group 3 complex rehabilitative power wheelchairs. Effective July 1, fee schedule amounts for wheelchair accessories and back and seat cushions used with group 3 complex rehabilitative power wheelchairs will not be adjusted using information from the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The fee schedule amounts will be based on the unadjusted fee schedule amounts updated by the annual fee schedule covered item update. Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs with dates of service beginning July 1, 2017.

For more information, view the posting and FAQ on the DME Center web page.

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

MLN Matters® Number: SE1128 Revised

Release Date of Revised Article: August 23, 2017

This article was revised on August 23, 2017, to highlight upcoming system changes that identify the Qualified Medicare Beneficiary (QMB) status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.

Provider Types Affected

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

Provider Action Needed

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers and suppliers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Look for new information and messages in CMS' HIPAA Eligibility Transaction System (HETS) and the Provider Remittance Advice (RA) to identify patients' QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

Background

All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt discussed in Chapter 3 of the Provider Reimbursement Manual (Pub.15-1).

Refer to the Important Reminders Concerning QMB Billing Requirements Section below for key policy clarifications.

Inappropriate Billing of QMB Individuals Persists

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

Ways to Promote Compliance with QMB Billing Rules

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.

- Beginning November 4, 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS to verify a patient's QMB status and exemption from cost-sharing charges. For more information on HETS, see https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.
- Starting October 3, 2017, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare Provider RA, which will contain new notifications and information about a patient's QMB status. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.
- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.
- Providers and suppliers may also verify a patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

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

Important Reminders Concerning QMB Billing Requirements

Be aware of the following policy clarifications on QMB billing requirements:

1. All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must abide by the billing prohibitions.

2. Individuals enrolled in the QMB program retain their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different State than the State in which care is rendered.

3. Note that individuals enrolled in QMB cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

QMB Eligibility and Benefits

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

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

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

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

Additional Information

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

Provider Enrollment Revalidation – Cycle 2- Second Revision

MLN Matters® Number: SE1605 Revised

This article was revised on June 15, 2017, to change the effective date of deactivations due to non-billings from 5 days from the date of the deactivation letter to 10 days. (See page 6.) All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

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

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

1. Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;

2. If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate. When either of these occur:

Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or

Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html;

If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and

- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

Background

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

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

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

your Medicare payments and possible deactivation of your Medicare billing privileges. Generally, this due date will remain with the provider/supplier throughout subsequent revalidation cycles.

The list will be available at http://go.cms.gov/MedicareRevalidation and will include all enrolled providers/suppliers. Those due for revalidation will display a revalidation due date, all other providers/suppliers not up for revalidation will display a "TBD" (To Be Determined) in the due date field. In addition, a crosswalk to the organizations that the individual provider reassigns benefits will also be available at http://go.cms.gov/MedicareRevalidation on the CMS website.

- IMPORTANT: The list identifies billing providers/suppliers only that are required to revalidate. If you are enrolled solely to order, certify, and/or prescribe via the CMS-855O application or have opted out of Medicare, you will not be asked to revalidate and will not be reflected on the list.
- Due dates are established based on your last successful revalidation or initial enrollment (approximately 3 years for DME suppliers and 5 years for all other providers/suppliers).
- In addition, the MAC will send a revalidation notice within 2-3 months prior to your revalidation due date either by email (to email addresses reported on your prior applications) or regular mail (at least two of your reported addresses: correspondence, special payments and/or your primary practice address) indicating the provider/supplier's due date.
- Revalidation notices sent via email will indicate "URGENT: Medicare Provider Enrollment Revalidation Request" in the subject line to differentiate from other emails. If all of the emails addresses on file are returned as undeliverable, your MAC will send a paper revalidation notice to at least two of your reported addresses: correspondence, special payments and/or primary practice address.

NOTE: Providers/suppliers who are within 2 months of their listed due dates on http://go.cms.gov/MedicareRevalidation but have not received a notice from their MAC to revalidate, are encouraged to submit their revalidation application.

- To assist with submitting complete revalidation applications, revalidation notices for individual group members, will list the identifying information of the organizations that the individual reassigns benefits.

Large Group Coordination

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

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

Unsolicited Revalidation Submissions

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

- What is an unsolicited revalidation?

If you are not due for revalidation in the current 6 month period, your due date will be listed as "TBD" (To Be Determined). This means that you do not yet have a due date for revalidation. Please do not submit a revalidation application if there is NOT a listed due date.

Any off-cycle or ad hoc revalidations specifically requested by CMS or the MAC are not considered unsolicited revalidations.

- If your intention is to submit a change to your provider enrollment record, you must submit a 'change of information' application using the appropriate CMS-855 form.

Submitting Your Revalidation Application

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

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

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

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

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

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

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

Getting Access to PECOS:

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

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

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

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

Deactivations Due to Non-Response to Revalidation or Development Requests

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

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

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

Revalidation Timeline and Example

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

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2017
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2017
MAC sends email/letter notification	75 – 90 days prior to due date	July 2 - 17, 2017
MAC sends letter for undeliverable emails	75 – 90 days prior to due date	July 2 - 17, 2017
Revalidation due date		
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2017
Deactivate	60 – 75 days after due date	7

Deactivations Due to Non-Billing

Providers/suppliers that have not billed Medicare for the previous 12 consecutive months will have their Medicare billing privileges deactivated in accordance with 42 CFR §424.540. The effective date of deactivation will be 10 days from the date of the corresponding deactivation letter issued by the MACs notifying the providers/suppliers of the deactivation action.

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

Application Fees

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

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

Summary:

CMS will post the revalidation due dates for the upcoming revalidation cycle on http://go.cms.gov/MedicareRevalidation for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.

- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple

reassignments/billing structures, you must coordinate the revalidation application submission with all parties.

- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If the provider/supplier has not billed Medicare for the previous 12 consecutive months, the MAC will deactivate their Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional Information

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

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

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

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

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

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

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

Modernized National Plan and Provider Enumeration System

MLN Matters Number: SE17016

Article Release Date: June 27, 2017

Provider Types Affected

This MLN Matters® Article is intended for all health care providers — users of the National Plan and Provider Enumeration System (NPPES) to obtain, or update a National Provider Identifier (NPI) and to maintain their NPI account. This includes all physicians, providers and suppliers—it is not limited or restricted to Medicare.

Provider Action Needed

The Centers for Medicare & Medicaid Services has modernized the NPPES (NPPES 3.0) that now has unified login for type 1 and type 2 providers which increases security, provides new surrogacy functionality, has a more responsive User Interface (UI) and a streamlined NPI application process. All NPPES users who obtain and manage NPI account information should be aware of these new and improved features/processes, especially those who support Type 2 providers. NPPES has implemented a more efficient way of accessing type 2 NPI accounts so providers no longer need separate credentials for type 2 accounts and are no longer inclined to share these credentials.

Background

The NPI is the standard for a unique identifier for health care providers for use in the health care system. NPPES is the application that health care providers must use to be awarded an NPI number. Within the NPPES, there are two types of providers:

- Type 1 Providers – Health care providers who are individuals, including physicians, dentists, and all sole proprietors (An individual is eligible for only one NPI.)
- Type 2 providers – Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

For more information on the National Provider Number please visit https://www.cms.gov/Regulations-and-Guidance/Administrative- Simplification/NationalProvIdentStand/downloads/NPIfinalrule.pdf.

New NPPES Impact on Type 1 Providers

Type 1 providers who already have an account in the Identity & Access (I&A) Management System may login to NPPES without incident. Type 1 providers who do not have an I&A account will need to create an account by visiting https://nppes.cms.hhs.gov/IAWeb/login.do.

Under the modernized NPPES, surrogates of Type 1 providers will have access to their Type 1 provider's NPI records.

For more information on the Identity & Access Management System please visit https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf.

New NPPES Impact on Type 2 Providers

In the past, the sharing of login credentials between Type 2 providers and surrogates posed great security risks including fraud and provider identity theft. The new unified login and surrogacy helps lessen these risks and increase account security. Type 2 provider users will need I&A authentication credentials to access the modernized NPPES. Users may obtain these in the I&A system by going to https://nppes.cms.hhs.gov/IAWeb/login.do. The Authorized Officials (AO) and Delegated Officials (DO) in I&A of Type 2 providers will be able to access all NPIs under the Employer Identification Number (EIN) on the type 2 provider with an organization EIN. Users can claim NPIs using their legacy Type 2 usernames and passwords after they login with an I&A account. As an additional convenience, large organizations can contact the enumerator to get access to their NPIs. More information on the types of possible user roles is available at https://nppes.cms.hhs.gov/IAWebContent/Quick_Reference_Guide.pdf.

Key Features of the Modernized NPPES

Some of the key features of the modernized and more responsive UI include:

- If users have an I&A user ID and password, they now can use those credentials to login to NPPES and they can access all NPIs from one unified account.
- Users can save applications that are not fully complete and may continue where they left off when they return to the NPPES.
- NPPES will have smart filters that only display entries containing the data entered by users to filter away unnecessary information.
- Users may add more than one practice location to their NPI application.
- All taxonomy information may be completed on one page due to the smart filter technology of NPPES 3.0.
- Surrogacy allows administrative users the ability to update records in NPPES on behalf of a provider.
- NPPES 3.0 provides a help option to give assistance to the user based on the screen on which they are working.
- Increased security because NPPES now uses surrogacy functionality for Type 2 NPIs to prevent sharing of Type 2 login credentials.

Electronic File Interchange (EFI) Features

NPPES 3.0 will continue to allow providers and surrogates to submit multiple NPI applications at one time using Comma Separated Values (CSV) files. To use the EFI feature, the users will need to apply for EFI access. This can be done by logging into NPPES and clicking the 'Manage EFI' button on the bottom of the NPPES homepage. The EFI access application is pre-populated with some of the user's information pre-filled when it is generated. For more information on EFI functionality please visit https://nppes.cms.hhs.gov/webhelp/nppeshelp/EFI%20HELP%20PAGE.html.

Data Dissemination File (DDS) Enhancements

NPPES will generate weekly and monthly Org Other Name, Practice Location Addresses, and Endpoint Information Files. The weekly files will have updates of the information that changes from week to week, while the monthly files will generate regardless of updated information. DDS files with PII will continue to be delivered to stakeholders, while DDS files without PII will continue to be delivered to http://download.cms.gov/nppes/NPI_Files.html.

New Optional Fields in NPPES 3.0

The following new fields will allow the user to give more information about the provider and the practice location:

- Primary languages
- Secondary languages
- Race and ethnicity
- Accessibility of the location to users with mobility disabilities
- Provider's office hours of operation
- Provider's direct email address

Frequently Asked Questions

Feel free to visit the NPPES web help guide to see solutions to frequently asked questions. That guide is available at https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html.

Additional Information

Additional Information on NPPES is available at the following links:

https://www.youtube.com/watch?v=BOJCAj1P2u8&feature=youtu.be

https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#How-can-I-gain-access-to-my-Type-2-NPI

https://nppes.cms.hhs.gov/webhelp/nppeshelp/NPPES%20FAQS.html#Why-cant-I-use-my-Type-2-NPI-User-ID-and-Password-to-log-into-NPPES-to-access-my-NPI

https://nppes.cms.hhs.gov/IAWeb/warning.do?fwdurl=/

If you have any questions, please contact the NPI enumerator by phone at 1-800-465-3203 (NPI Toll-Free) or 1-800-692-2326 (NPI TTY), by email at customerservice@npienumerator.com or by regular mail at:

NPI Enumerator

PO Box 6059

Fargo, ND 58108-6059

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.
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.

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.
	• Oxygen break in service (BIS) issues
	• 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:
	  • K0 through K4
	  • GA
	  • GY
	  • GZ
	  • KX
	  • EY
	  • KG
	  • RA
	  • RB
	  • RP
	• Certain HCPCS codes (not all-inclusive list)
	  • B4159-B4162
	  • E0194
	  • E0128
	  • K0108
	  • K0462
	  • L4210
	  • All HCPCS in the Transcutaneous Electrical Nerve Stimulator (TENS) Policy
	  • All National Drug Codes (NDCs)

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

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.

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.

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 January 2017 through April 2017 are as follows:

- The L4361 review involved 704 claims, of which 462 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 66%.

Top Denial Reasons

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

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

Blood Glucose Test Strips (HCPCS A4253) Final Edit Effectiveness Results of Documentation Compliance Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code A4253KS. A Documentation Compliance Review (DCR) is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The final edit effectiveness results from April 2017 through June 2017 are as follows:

- The A4253KS review involved 4,871 claims, of which 2,564 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 53%.

Top Denial Reasons

- Denial 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 detail see, Blood Glucose Test Strips (HCPCS A4253) Final Edit Effectiveness Results of Documentation Compliance Review.

External Infusion Pumps (HCPCS E0781 and E0784) Final Edit Effectiveness Results of Documentation Compliance Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code E0781 and E0784. A Documentation Compliance Review (DCR) is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The final edit effectiveness results from November 2016 through June 2017 are as follows:

- The E0781 review involved 31 claims, of which 9 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 35%.
- The E0784 review involved 16 claims, of which 4 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 22%.

Top Denial Reasons

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

For complete detail see, External Infusion Pumps (HCPCS E0781 and E0784) Final Edit Effectiveness Results of Documentation Compliance Review.

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

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

- The A4253 review involved 540 claims, of which 516 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.

Top Denial Reasons

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

- Medical documentation was not received.
- Documentation does not support high utilization.
- An incorrect modifier was billed on the claim.

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

Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Final Edit Effectiveness Results of Documentation Compliance Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code J7507, J7517, J7518 and J7520. A Documentation Compliance Review (DCR) is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The final edit effectiveness results from April 2017 through July 2017 are as follows:

- The J7507 review involved 551 claims, of which 115 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 23%.
- The J7517 review involved 377 claims, of which 118 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 50%.
- The J7518 review involved 441 claims, of which 261 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 70%.
- The J7520 review involved 55 claims, of which 13 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 23%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Claim is a duplicate to a previously submitted claim.
- Detailed Written Order (DWO) was not received.
- Proof of Delivery (POD) was not received.

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

Knee-Ankle-Foot Orthosis 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 L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2126, L2128, L2132, L2134 and L2136. The final edit effectiveness results from May 2017 through June 2017 are as follows:

- The KAFO review involved 5 claims, of which 5 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.

Top Denial Reasons

- Claim is the same or similar to another claim on file.
- Claim is a duplicate to a previously submitted claim.
- Advance Beneficiary Notice (ABN) was not properly executed.
- Documentation does not support coverage criteria.

For complete detail see, Knee-Ankle-Foot Orthosis Final Edit Effectiveness Results of Service Specific Prepayment Review.

Knee Orthoses 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) L1810, L1812, L1820, L1830, L1831, L1832, L1833, L1834, L1836, L1840, L1843, L1844, L1845, L1846, L1847, L1848, L1850, L1851, L1852 and L1860. The quarterly edit effectiveness results from January 2017 through April 2017 are as follows:

- The KO review involved 95 claims, of which 88 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 96%.

Top Denial Reasons

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

For complete detail see, Knee Orthoses 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 January 2017 through April 2017 are as follows:

- The L1832 review involved 139 claims, of which 139 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.
- The L1843 review involved 117 claims, of which 117 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

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

Manual Wheelchair (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 January 2017 through April 2017 are as follows:

- The K0001 review involved 1,033 claims, of which 547 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 45%.
- The K0003 review involved 230 claims, of which 153 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

Top Denial Reasons

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

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

Nebulizer Inhalation Drugs (HCPCS J7605 and J7626) Final Edit Effectiveness Results of Documentation Compliance Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code J7605 and J7626. A Documentation Compliance Review (DCR) is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The final edit effectiveness results from April 2017 through June 2017 are as follows:

- The J7605 review involved 283 claims, of which 71 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 27%.
- The J7626 review involved 660 claims, of which 197 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 31%.

Top Denial Reasons

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

For complete detail see, Nebulizer Inhalation Drugs (HCPCS J7605 and J7626) Final Edit Effectiveness Results of Documentation Compliance Review.

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

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

- The E1390 review involved 729 claims, of which 73 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 10%.

Top Denial Reasons

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

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

Positive Airway Pressure (PAP) Devices (HCPCS E0601KH) 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) E0601KH. The quarterly edit effectiveness results from January 2017 through April 2017 are as follows:

- The E0601KH review involved 2,756 claims, of which 933 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 26%.

Top Denial Reasons

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

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

Positive Airway Pressure (PAP) Devices (HCPCS E0601KJ) 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 E0601KJ. The final edit effectiveness results from February 2017 through June 2017 are as follows:

- The E0601KJ review involved 1,134 claims, of which 358 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 36%.

Top Denial Reasons

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

For complete detail see, Positive Airway Pressure (PAP) Devices (HCPCS E0601KJ) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Prior Authorization Condition of Payment for HCPCS Codes K0856 and K0861 - Expanding Nationwide July 17, 2017

CMS has announced that the Prior Authorization Condition of Payment Program for HCPCS codes K0856 and K0861 is expanding nationwide for dates of service/delivery on or after July 17, 2017. Suppliers submitting claims for beneficiaries residing in any state must receive prior authorization affirmation for the following two HCPCS codes as a condition for payment before the item can be furnished or a claim can be submitted:

- K0856: Power wheelchair, group 3 standard., single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0861: Power wheelchair, group 3 standard., multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

Noridian has scheduled a webinar on July 19, 2017 at 11 a.m. Eastern Time to discuss these changes and what they mean to your facility. Visit the Schedule of Events page to register for this webinar and watch for additional information to be posted on the Latest Updates section of the website. More information can also be found on the CMS website.

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 January 2017 through April 2017 are as follows:

- The L0648 review involved 399 claims, of which 314 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.
- The L0650 review involved 1,126 claims, of which 986 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 88%.

Top Denial Reasons

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

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

Targeted Probe and Educate (TPE) Pilot – Effective July 3, 2017

Beginning July 3, 2017, CMS has authorized the Jurisdiction D MAC to conduct the Targeted Probe and Educate (TPE) Pilot review process. TPE will include up to three rounds of supplier-specific prepayment probe reviews followed by education to for identified errors. The goal of TPE is to improve the claims payment error rate and reduce the volume of appeals through claim review and education.

If a high error rate persists following the maximum rounds of review and education, Noridian will refer the supplier to CMS for possible further action. In addition, discontinuation of TPE may occur at the conclusion of any round if sufficient improvement is achieved through claim review.

For complete details see the Targeted Probe and Educate (TPE) Pilot page of the Noridian website.

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 January 2017 through April 2017 are as follows:

- The A4351 review involved 1,242 claims, of which 592 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 45%.
- The A4353 review involved 151 claims, of which 114 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 75%.
- The A4358 review involved 1,142 claims, of which 827 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 69%.

Top Denial Reasons

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

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

CMS-1500 Claim Form Must Be the 02/12 Version

Effective August 30, 2017 any CMS-1500 paper claim form submitted for DME claims that is on a version other than the current 02/12 version will be returned to the supplier. Per CMS, version 02/12 is the only acceptable version of the CMS-1500 claim.

The version number 02/12 is on the top of the claim form and in the lower right hand corner.

Noridian has been made aware of at least one print vendor that is selling the outdated version 09/19 of the CMS-1500 claim form. This version of the form is not accepted and claims submitted on this version will be returned. Any claim forms returned, will need to be resubmitted on the current version.

Suppliers are responsible for purchasing their own CMS-1500 claim forms. Forms can be obtained from printers or printed in-house if they follow the specifications developed by the National Uniform Claim Committee (NUCC). Photocopies of the CMS-1500 claim form are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the CMS-1500 claim form for processing. The 02/12 version of the CMS-1500 claim form may be purchased from the U.S. Government Printing Office website or by calling 202-512-1800. Other print vendors also offer the 02/12 version of the claim form. Reference the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Publication 100-04, Chapter 26, Section 10 for more information.

RT and LT Modifier No Longer Required for Electronic Claims

Effective July 3, 2017, the RT and LT modifiers will no longer be required as a second or third modifier for bilateral items on electronic claims. Common Electronic Data Interchange (CEDI) has removed the front-end edit that required the RT and LT modifiers for bilateral capped rental items when two units of service are billed on the same claim line. This update will also affect claims billed for options and accessories that are used to make a base unit functional. Removal of this edit will allow modifiers to be reported on the claim in a format that is compatible with the Medicare claims processing system.

When a bilateral capped rental code requires more than four modifiers, the 99 modifier should continue to be reported. For example, when billing for two units of E0994 (Arm Rest, each) the claim line will be billed as E0994NURBKX99. The narrative section of the claim should include all modifiers needed for billing including any applicable competitive bid modifiers (ex. NURBKXKHRTLT.)

Cures Act Adjustments and Competitive Bidding

Noridian has received some questions about how competitively bid items are affected by the Cures Act adjustments. These items are outlined below.

Change Request 9968 states "Contractors shall create a one-time process to validate and adjust claims using the new 2016 DMEPOS fee schedule file when the following is true…" The following requirements are adapted from this change request, as directed by CMS.

- Date of service is from July 1, 2016, through December 31, 2016.
- The HCPCS is one eligible for the Cures Act adjustments as listed in Attachment A (beginning on page 10) of CR9968.
- The beneficiary did not reside in a current Round 1 or Round 2 competitive bid area.
- The beneficiary's address was in a current Round 1 or Round 2 competitive bid area, but the DMEPOS item in question was grandfathered.
- The beneficiary's address was in a current Round 1 or Round 2 competitive bid area, but the item was a wheelchair accessory and the KY modifier was reported on the claim.

If a DMEPOS item was part of competitive bid and the beneficiary resided in a competitive bid area, no Cures Act adjustment will be done since the claim originally paid at the contractual price and no additional payment is allowed.

Correct Coding – A5513 Custom Molding Requirements

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - A5513 Custom Molding Requirements" is now available on our (Noridian) website.

View the complete Correct Coding – A5513 Custom Molding Requirements webpage.

Correct Coding - A5513 Product Coding Redetermination Project

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - A5513 Product Coding Redetermination Project" is now available on our (Noridian) website.

View the complete Correct Coding – A5513 Product Coding Redetermination Project webpage.

Correct Coding - Bariatric Pressure Reducing Support Surfaces

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Bariatric Pressure Reducing Support Surfaces" is now available on our (Noridian) website.

View the complete Correct Coding – Bariatric Pressure Reducing Support Surfaces webpage.

Correct Coding - Center Mount Elevating Leg Rest

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Center Mount Elevating Leg Rest" is now available on our (Noridian) website.

View the complete Correct Coding - Center Mount Elevating Leg Rest webpage.

Correct Coding - Center Mount Elevating Leg Rest – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Center Mount Elevating Leg Rest - Revised" has been updated.

Summary of changes: Corrects an error in the billing information for codes E1012 and K0040.

View the complete Correct Coding - Center Mount Elevating Leg Rest - Revised webpage.

Correct Coding - SpeediCath Flex Coudé Catheter (Coloplast)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - SpeediCath® Flex Coudé Catheter (Coloplast)" is now available on our (Noridian) website.

View the complete Correct Coding - SpeediCath® Flex Coudé Catheter (Coloplast) webpage.

Correct Coding - Submitting Diabetic Shoe Inserts for HCPCS Coding - PDAC Coding Application Instruction

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Submitting Diabetic Shoe Inserts for HCPCS Coding - PDAC Coding Application Instruction" is now available on our (Noridian) website.

View the complete Correct Coding - Submitting Diabetic Shoe Inserts for HCPCS Coding - PDAC Coding Application Instruction webpage.

Face-to-Face and Written Order Requirements for Certain Types of DME – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Face-to-Face and Written Order Requirements for Certain Types of DME" has been updated.

Publication Date: August 2017

- Revised: Clarifies Date and Timing Requirements for documentation associated with 42 CFR 410.38(g).
- Added: Link to CMS website in place of Table for items specified per 42 CFR 410.38(g)

View the complete Face-to-Face and Written Order Requirements for Certain Types of DME webpage.

LCD and Policy Article Revisions Summary for June 29, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for June 29, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for June 29, 2017 webpage.

LCD and Policy Article Revisions Summary for August 24, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for August 24, 2017" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for August 24, 2017 webpage.

LCD and Policy Article Summary for June 8, 2017 – Drafts Released to Final

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Summary for June 8, 2017 – Drafts Released to Final" is now available on our (Noridian) website.

View the complete LCD and Policy Article Summary for June 8, 2017 – Drafts Released to Final webpage.

Policy Article Revisions Summary for June 8, 2017

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Policy Article Revisions Summary for June 8, 2017" is now available on our (Noridian) website.

View the complete Policy Article Revisions Summary for June 8, 2017 webpage.

Surgical Dressings Comments and Response Summary

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Surgical Dressings Comments and Response Summary" is now available on our (Noridian) website.

View the complete Surgical Dressings Comments and Response Summary webpage.

MLN Connects – June 1, 2017

MLN Connects® for Thursday, June 1, 2017

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News & Announcements

- New Medicare Cards Offer Greater Protection to More Than 57.7 Million Americans
- EHR Incentive Programs: Submit Comments on Proposed Changes by June 13
- New Quality Payment Program Resources Available
- Review 2017 EHR Incentive Program Requirements
- CY 2017 eCQM Resources and Tools

Provider Compliance

- Automatic External Defibrillators: Inadequate Medical Record Documentation

Claims, Pricers & Codes

- Hospices: Submit Adjustments to Correct Payment Errors

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network Publications & Multimedia

- Required Workaround for Hospices Submitting RHC and SIA Payments at the End of Life MLN Matters Article — New
- SBIRT Services Booklet — Revised
- Medicare Basics: Parts A and B Claims Overview Video — Reminder
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Reminder

MLN Connects – June 8, 2017

MLN Connects® for Thursday, June 8, 2017

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News & Announcements

- Hospitals and SNFS: Reduce Legionella Risk in Water Systems
- Predictive Qualifying APM Participant Status Announced
- Hospices: Review First Provider Preview Reports by June 30
- IRFs & LTCHs: Review QRP Provider Preview Reports by June 30
- IRF and LTCH Compare Quarterly Refresh
- PEPPER for Short-term Acute Care Hospitals Available
- Quality Payment Program Resources Available
- ONC eMeasurement and Quality Improvement Webinar: Recording Available
- Proposed Revisions to Long-Term Care Facilities' Arbitration Agreements
- World No Tobacco Day

Provider Compliance

- Duplicate Claims Will Not be Paid

Claims, Pricers & Codes

- July 2017 Average Sales Price Files Available

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call — June 15
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network Publications & Multimedia

- Quality Payment Program Overview Web-Based Training Course — New
- Scheduled End of the Intravenous Immune Globulin Demonstration MLN Matters® Article — New
- Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians Booklet — Reminder
- Medicare Secondary Payer Booklet — Reminder

MLN Connects – June 15, 2017

MLN Connects® for Thursday, June 15, 2017

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News & Announcements

- MIPS Group Reporting: Registration Period Ends June 30
- MIPS Performance Categories: Accepting Future Measures and Activities until June 30
- Chronic Care Management Services: New Connected Care Materials
- National Men's Health Week 2017
- County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges

Provider Compliance

- CMS Provider Minute: CT Scans Video

Claims, Pricers & Codes

- 2018 ICD-10-CM Code Files Available

Upcoming Events

- IMPACT Act Special Open Door Forum — June 20
- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Diagnosis and Treatment of Parkinson's Disease Webinar — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29

Medicare Learning Network Publications & Multimedia

- Guidance to Providers that Submit Outpatient Facility Claims and Those That Enter Claims Data via DDE Screens to Reduce Incidence of Claims Not Crossing Over MLN Matters® Article — New

MLN Connects – June 22, 2017

MLN Connects® for Thursday, June 22, 2017

View this edition as a PDF

News & Announcements

- CMS Proposes Quality Payment Program Updates to Increase Flexibility and Reduce Burdens
- Coming in April 2018: New Medicare Card – New Number
- Quality Payment Program: New Resources Available
- Quality Payment Program: View Recordings of Recent Webinars
- Quality Measure Development Plan Annual Report
- SNF QRP Review and Correct Reports Available
- 2015 Physician and Other Supplier Utilization and Payment Data
- 2015 Referring DMEPOS Utilization and Payment Data
- Hospice QRP: Clarifying Coding Guidance for Hospice Item Set
- IRFs & LTCHs: Reminder to Review QRP Provider Preview Reports by June 30
- Hospices: Reminder to Review Provider Preview Reports by June 30
- Minority Research Grant Program: Apply by July 10

Provider Compliance

- Hospice Election Statements Lack Required Information or Have Other Vulnerabilities

Upcoming Events

- CLIA Certificate of Provider-performed Microscopy Webcast — June 28
- Improvements to the Medicare Claims Appeal Process and Statistical Sampling Call — June 29
- Quality Payment Program Year 2 Proposed Rule Listening Session — July 5
- Creating and Verifying Your National Provider Identifier Call — July 12

Medicare Learning Network Publications & Multimedia

- Provider Enrollment Revalidation – Cycle 2 MLN Matters Article — Revised
- Complying with Medical Record Documentation Requirements — Revised

MLN Connects – June 29, 2017

MLN Connects® for Thursday, June 29, 2017

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News & Announcements

- New Medicare Number: Prepare Your Systems for April 2018
- DMEPOS: Payment for Group 3 Complex Rehabilitative Power Wheelchair Accessories Effective July 1
- Quarterly Provider Update

Provider Compliance

- Evaluation and Management: Correct Coding

Upcoming Events

- Quality Payment Program Year 2 Proposed Rule Listening Session — July 5
- DMEPOS Prior Authorization Special Open Door Forum – July 6
- ESRD QIP: Reviewing Your Facility's PY 2018 Performance Data — July 10
- Creating and Verifying Your National Provider Identifier Call — July 12

Medicare Learning Network Publications & Multimedia

- Behavioral Health Integration Services Fact Sheet — New
- Evaluation and Management Services Web-Based Training Course — New
- Dementia Care Call: Audio Recording and Transcript — New
- Medical Privacy of Protected Health Information Fact Sheet — Revised
- Medicare Basics: Commonly Used Acronyms Educational Tool — Revised

MLN Connects – July 6, 2017

MLN Connects® for Thursday, July 6, 2017

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News & Announcements

- ESRD: Proposed 2018 Policy and Payment Rate Changes
- ESRD QIP: Prepare for the PY 2018 Preview Period
- QPP: New Resources to Help Clinicians Participate in MIPS
- QPP: New Webpage for Clinicians in Small, Rural, or Underserved Areas
- Open Payments Program Posts 2016 Financial Data

Provider Compliance

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

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2018 Performance Data Call — July 10
- Creating and Verifying Your National Provider Identifier Call — July 12
- Assessing Your Ability to Support Patient Self-Management Webinar — July 19
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26

Medicare Learning Network Publications & Multimedia

- Modernized National Plan and Provider Enumeration System MLN Matters Article — New
- Infection Control: Hand Hygiene Video — New
- PECOS for Provider and Supplier Organizations Booklet — Reminder
- Medicare Vision Services Fact Sheet — Reminder
- Mass Immunizers and Roster Billing Booklet — Reminder

MLN Connects – July 13, 2017

MLN Connects® for Thursday, July 13, 2017

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News & Announcements

- New Medicare Cards with New Numbers: 3 Changes You May Need to Make
- QRDA III Implementation Guide Available
- Quality Payment Program: View Recent Webinar Recordings
- Hospital Discharge Notices
- IPPS Hospitals: FY 2014 S-10 Revisions
- Recognizing National HIV Testing Day

Provider Compliance

- OIG Video: Reporting Fraud to the Office of the Inspector General

Claims, Pricers & Codes

- ICD-10-CM Errata Available

Upcoming Events

- Revised Interpretive Guidance for Nursing Homes and New Survey Process Call — July 25
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26
- IRF Quality Reporting Program Refresher Training Webinar — August 15
- Comparative Billing Report on Drugs of Abuse Testing Webinar — August 23

Medicare Learning Network Publications & Multimedia

- CLIA Webcast: Audio Recording and Transcript — New
- Appeals Call: Audio Recording and Transcript — New
- Acute Care Hospital Inpatient Prospective Payment System Booklet — Reminder
- Skilled Nursing Facility Prospective Payment System Booklet — Reminder
- Ambulatory Surgical Center Fee Schedule Fact Sheet — Reminder
- Ambulance Fee Schedule Fact Sheet — Reminder
- Health Professional Shortage Area Physician Bonus Program Fact Sheet — Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool — Reminder

MLN Connects – July 20, 2017

MLN Connects® for Thursday, July 20, 2017

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News & Announcements

- Home Health Agency CoP Final Rule: Effective Date Extended to January 13, 2018
- Hospice Quality Reporting Program: Non-Compliance Letters
- IRF Quality Reporting Program: Non-Compliance Letters
- LTCH Quality Reporting Program: Non-Compliance Letters
- SNF Quality Reporting Program: Non-Compliance Letters
- IRF, LTCH, and SNF Quality Reporting Program Data due August 15
- New PEPPER Available for Home Health Agencies and Partial Hospitalization Programs
- Hospitals: 2018 QRDA Category I Implementation Guide
- Health Care Fraud Takedown: Charges Against Individuals Responsible for $1.3 Billion in Fraud

Provider Compliance

- Billing For Stem Cell Transplants

Claims, Pricers & Codes

- Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H31312

Upcoming Events

- Revised Interpretive Guidance for Nursing Homes and New Survey Process Call — July 25
- ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26
- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments - Listening Session — August 1
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health Quality Reporting Program Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22

Medicare Learning Network Publications & Multimedia

- Quality Payment Program Listening Session: Audio Recording and Transcript — New
- Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool — New
- Medicare Basics: Parts A and B Claims Overview Video — Reminder
- Chronic Care Management Services Fact Sheet — Reminder

MLN Connects – July 27, 2017

MLN Connects® for Thursday, July 27, 2017

View this edition as a PDF

News & Announcements

- Home Health Agencies: CMS Proposes 2018 and 2019 Payment Changes
- New Medicare Card (formerly called SSNRI)
- Quality Payment Program: Explanation of Special Status Calculation
- Updated CMS Measures Inventory Posted
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis
- Anniversary of the American Disabilities Act

Provider Compliance

- Hospital Discharge Day Management Services CMS Provider Minute Video

Claims, Pricers & Codes

- 2018 ICD-10-CM POA Exempt Codes Available

Upcoming Events

- New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments Listening Session — August 1
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22
- CMS National Provider Enrollment Conference — September 6 and 7

Medicare Learning Network Publications & Multimedia

- Quality Payment Program 2017 MIPS: Improvement Activities Performance Category Web-Based Training Course — New
- Provider/Supplier Enrollment Call: Audio Recording and Transcript — New
- Medicare Part B Immunization Billing Educational Tool — Reminder

MLN Connects – August 3, 2017

MLN Connects® for Thursday, August 03, 2017

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News & Announcements

- CMS Updates Medicare Payment Rates, Quality Reporting Requirements
- Hospice Benefit: FY 2018 Updates to the Wage Index and Payment Rates
- IRFs: Final FY 2018 Payment and Policy Changes
- SNFs: Final FY 2018 Payment and Policy Changes
- SNF Quality Reporting Program: Reconsideration Period Ends August 13
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Vaccines are Not Just for Kids

Provider Compliance

- Reporting Changes in Ownership

Claims, Pricers & Codes

- ICD-10 GEMS for 2018 Available

Upcoming Events

- SNF Quality Reporting Program: Review and Correct Reports Refresher Training Webinar — August 7
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- CMS National Provider Enrollment Conference — September 6 and 7
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Comparative Billing Report on IPPE/AWV Webinar — September 13

Medicare Learning Network Publications & Multimedia

- Medicare Part B Immunization Billing Educational Tool — Revised
- The ABCs of the Annual Wellness Visit Educational Tool — Reminder

MLN Connects – August 10, 2017

MLN Connects® for Thursday, August 10, 2017

View this edition as a PDF

News & Announcements

- New Medicare Card: Webpage Updates
- IRF Quality Reporting Program: Reconsideration Period Ends August 17
- LTCH Quality Reporting Program: Reconsideration Period Ends August 17
- Hospice Quality Reporting Program: Reconsideration Period Ends August 17
- EHR Incentive Program Hardship Exception Application Due by October 1
- Hospitals: Submit Meaningful Use Data to the HQR via the QualityNet Secure Portal in 2018
- Chronic Care Management: New Connected Care Videos
- Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician
- Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available
- Quality Payment Program Hardship Exception Application for 2017 Transition Year Open
- Quality Payment Program: Explanation of Special Status Calculation — Correction

Provider Compliance

- Home Health Care: Proper Certification Required

Claims, Pricers & Codes

- July 2017 OPPS Pricer File
- Part B Billing for Certain New Biosimilar Biological Products before the Modifier is Implemented

Upcoming Events

- IRF Quality Reporting Program Refresher Training Webinar — August 15
- Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
- Quality Payment Program Year 2 NPRM Virtual Office Hours Session — August 16
- IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
- LTCH Quality Reporting Program Refresher Training Webinar — August 22
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7

Medicare Learning Network Publications & Multimedia

- August 2017 Catalog Available
- Quality Payment Program 2017: MIPS Quality Performance Category Web-Based Training Course — New
- Long-Term Care Call: Audio Recording and Transcript — New
- ESRD Listening Session: Audio Recording and Transcript — New
- Medicare Secondary Payer Web-Based Training Course — Revised
- Medicare Secondary Payer Booklet — Revised

MLN Connects – August 17, 2017

MLN Connects® for Thursday, August 17, 2017

View this edition as a PDF

News & Announcements

- CMS Releases Hospice Compare Website to Improve Consumer Experiences, Empower Patients
- Proposed Changes to Comprehensive Care for Joint Replacement Model, Cancellation of Other Models
- CMS Releases Updated Data on Medicare Hospice Utilization and Payment
- SNF Quality Reporting Program Web-based Training Module Available
- Beneficiary Notices: Large Print Forms Available

Provider Compliance

- Inpatient Skilled Nursing Facility Denials

Claims, Pricers & Codes

- 2018 ICD-10-CM Coding Guidelines and Conversion Table Available

Upcoming Events

- IMPACT Act: Medicare Spending Per Beneficiary Measures Call — September 6
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7

Medicare Learning Network Publications & Multimedia

- Care Management Listening Session: Audio Recording and Transcript — New
- Medicare Parts A & B Appeals Process Booklet— Revised
- DMEPOS Information for Pharmacies Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet – Revised

MLN Connects – August 24, 2017

MLN Connects® for Thursday, August 24, 2017

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News & Announcements

- CMS Launches Jimmo Settlement Agreement Webpage
- Provider Compliance
- CMS Provider Minute: Preventive Services Video

Upcoming Events

- IMPACT Act: Medicare Spending Per Beneficiary Measures Call — September 6
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Qualified Medicare Beneficiary Program Billing Rules Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28
- Comparative Billing Report on Modifier 25 Dermatology Webinar — October 11

Medicare Learning Network Publications & Multimedia

- Mass Immunizers and Roster Billing Booklet — Revised
- Beneficiaries in Custody under a Penal Authority Fact Sheet — Revised
- Chronic Care Management Services Changes for 2017 Fact Sheet — Reminder

MLN Connects – August 31, 2017

MLN Connects® for Thursday, August 31, 2017

View this edition as a PDF

News & Announcements

- New PEPPER Available for Short-term Acute Care Hospitals
- Hospice Compare Update Document Available
- Participate in Quality Payment Program Website Testing
- Departmental Appeals Board: Submit Feedback
- Correction to QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals

Provider Compliance

- Billing For Stem Cell Transplants

Upcoming Events

- IMPACT Act: Medicare Spending Per Beneficiary Measures Call — September 6
- Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
- Qualified Medicare Beneficiary Program Billing Requirements Call — September 19
- Reporting Hospice Quality Data: Tips for Compliance Call — September 20
- PQRS: Feedback Reports and Informal Review Process for PY 2016 Results Call — September 26
- Physician Compare Call — September 28

Medicare Learning Network Publications & Multimedia

- IMPACT Act Call: Audio Recording and Transcript — New
- A Physician's Guide to Medicare Part D Medication Therapy Management Programs MLN Matters Article — Revised
- Preventive Services Poster Educational Tool — Revised
- Medicare Costs at a Glance: 2017 Educational Tool — Reminder
- Suite of Products & Resources for Rural Health Providers Educational Tool — Reminder
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet — Reminder
- Physician Fee Schedule Fact Sheet — Reminder
- Telehealth Services Fact Sheet — Reminder
- Transitional Care Management Services Fact Sheet — Reminder
- Federally Qualified Health Center Fact Sheet — Reminder
- Rural Health Clinic Fact Sheet — Reminder
- Medicare Home Health Benefit Booklet — Reminder
- Critical Access Hospital Booklet — Reminder

MLN Connects Special Edition – August 31, 2017

- CMS Helping Texas and Louisiana with Hurricane Harvey Recovery
- Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — New
- Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — New

CMS Helping Texas and Louisiana with Hurricane Harvey Recovery

On August 30, 2017, the Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma announced the efforts that are underway to support Texas and Louisiana in response to Hurricane Harvey. Earlier this week, Health and Human Services Secretary Tom Price, M.D., declared public health emergencies in both States. Actions include temporarily waiving or modifying certain Medicare, Medicaid and Children's Health Insurance Program (CHIP) requirements to provide immediate relief to those affected by the hurricane and resulting floods.

"In light of the natural disaster still unfolding in Texas and Louisiana, CMS is committed to acting as quickly and effectively as possible so the States can continue to ensure the vital health care needs of our most vulnerable beneficiaries are not interrupted," said CMS Administrator Seema Verma. "CMS is in constant communication with officials in Texas and Louisiana to be sure we are doing all we can to support those in the path of this historic and devastating storm."

CMS and the U.S. Department of Health and Human Services (HHS) are working in close coordination with the Kidney Community Emergency Response (KCER) Network and the States of Texas and Louisiana to ensure that beneficiaries have access to facilities to provide their treatments. As the CMS response continues, other efforts include, supporting Texas and Louisiana in arranging Special Purpose Renal Dialysis Facilities, transporting patients to facilities and arranging for new facilities to open in order to serve beneficiaries without interruption. In Texas, CMS is coordinating with the workforce on the ground that cares for renal patients to ensure there are enough facilities to serve beneficiaries in need of dialysis. The agency is accepting requests from end stage renal disease suppliers to become a temporary Special Purpose Renal Dialysis Facility (SPRDF).

Since the public health emergencies were declared, CMS has offered immediate administrative relief actions to Texas and Louisiana including issuing several general waivers of certain requirements for specific types of providers in impacted counties and geographical areas. These waivers work to prevent gaps in access to care for beneficiaries.

Skilled Nursing Facilities (SNF): CMS waives requirements for a 3-day prior hospitalization before admission in order to receive Medicare SNF services and provides temporary emergency coverage of services in SNFs without a qualifying hospital stay for people who are evacuated, transferred, or otherwise dislocated due to Hurricane Harvey. Certain people with Medicare benefits who recently exhausted their SNF benefits are authorized for renewed coverage without first having to start a new benefit period.

Home Health Agencies: This CMS waiver provides relief to Home Health Agencies on the timeframes related to completion of OASIS (assessment data) Transmission.

Critical Access Hospitals (CAH): CMS waives the requirements limiting the number of patient beds to 25, and allows for length of stays beyond the capped 96-hour time period.

With the public health emergency in effect, CMS can also waive or modify certain Medicare provisions for providers, including certain deadlines, conditions of participation and certification requirements. Providers can now submit waiver requests to the state survey agency or the CMS regional office and they will be evaluated to ensure that they meet the requirements set out under the law. To help clarify billing instructions, CMS has issued technical direction to the Medicare Administrative Contractors regarding the waivers and has reminded area Medicare Advantage plans regarding their responsibilities to relax certain requirements during a disaster or emergency.

CMS will continue to work with the States of Texas and Louisiana. The agency continues to update our emergency page (www.cms.gov/emergency) with important information for state and local officials, providers, healthcare facilities and the public.

To read previous updates regarding HHS activities related to Hurricane Harvey, please visit https://www.hhs.gov/about/news.

To learn more about HHS resources related to Hurricane Harvey, please visit https://www.hhs.gov/hurricane-harvey.

Hurricane Harvey and Medicare Disaster Related Texas Claims MLN Matters Article — New

The President declared a state of emergency for Texas and the HHS Secretary declared a Public Health Emergency for Texas which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Hurricane Harvey and Medicare Disaster Related Texas Claims is available. Learn about blanket waivers CMS issued in the impacted counties and geographical areas in Texas. These waivers will prevent gaps in coverage for beneficiaries impacted by the emergency.

Check the Hurricanes webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.

Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims MLN Matters Article — New

The President declared a state of emergency for Louisiana and the HHS Secretary declared a Public Health Emergency for Louisiana which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Tropical Storm Harvey and Medicare Disaster Related Louisiana Claims is available. Learn about blanket waivers CMS issued in the impacted counties and geographical areas in Louisiana. These waivers will prevent gaps in coverage for beneficiaries impacted by the emergency.

Check the Hurricanes webpage for current information on temporary emergency policies and waivers. Additional waiver requests are being reviewed, and the webpage will be updated as decisions are made.

New Process for Providers and Suppliers Submitting Redeterminations and Reopenings via NMP - Effective June 16, 2017

Noridian has added a feature to the Noridian Medicare Portal (NMP). Providers and suppliers who submit their Redetermination and/or Reopening requests through NMP will now receive the Level 1 Medicare Redetermination Notices (MRNs) via NMP.

If a Redetermination or Reopening outcome results in a fully favorable (payable) determination, the Remittance Advice (RA) will continue as the method of communication. For all other decisions, in which providers had received an MRN, the determination letter will now be available through the Appeal Status Inquiry feature in NMP only.

This enhancement allows providers and suppliers, who submit such requests through NMP, the ability to print the determination letter and obtain their MRNs quickly and efficiently.

Because MRNs will no longer be mailed, please ensure that the appropriate staff is registered as an NMP user.

Noridian encourages the submission of electronic Reopening and Redetermination requests and all supporting documentation (10MB per file; unlimited file submission per claim) via NMP. This submission method ensures that the requests contain all required information, including the signature on Redetermination requests.

Payment for Accessories used with Group 3 Complex Rehabilitative Power Wheelchairs - Effective July 1, 2017

CMS is adopting a new interpretation of the statute that impacts how adjustments to the fee schedule based on information from competitive bidding programs apply to wheelchair accessories used with group 3 complex rehabilitative power wheelchairs. Effective July 1, fee schedule amounts for wheelchair accessories and back and seat cushions used with group 3 complex rehabilitative power wheelchairs will not be adjusted using information from the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program. The fee schedule amounts will be based on the unadjusted fee schedule amounts updated by the annual fee schedule covered item update. Suppliers should continue to use the KU modifier when billing for wheelchair accessories and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs with dates of service beginning July 1, 2017.

For more information, view the posting and FAQ on the DME Center web page.

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM10132
Related Change Request (CR) Number: 10132
Related CR Release Date: August 18, 2018
Effective Date: January 1, 2018
Related CR Transmittal Number: R3839CP
Implementation Date: January 2, 2018

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.

Provider Action Needed

Change Request (CR) 10132 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277, Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of these updates.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting, held each year in January or February, June, and in September or October. At these meetings, the Committee makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes.

The code sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claimstatus-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-statuscodes/. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2017 Committee meeting shall be posted on the above websites on or about November 1, 2017.

The Centers for Medicare & Medicaid Services (CMS) will issue instructions to the MACs who then must update their claims systems to ensure that the current version of these codes is used in their claim status responses.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR10132. References in CR10132 to "277 responses," and "claim status responses," encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional Information

The official instruction, CR10132, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R3839CP.pdf.

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

MLN Matters Number: MM10140
Related Change Request (CR) Number: CR10140
Related CR Release Date: August 18, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3841CP
Implementation Date: January 2, 2018

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 (DME) MACs and Home Health & Hospice MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 10140 instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2017.

Background

The Department of Health and Human Services (DHHS) adopted the Phase III CAQH CORE, EFT and ERA Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of DHHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

CAQH CORE will publish the next version of the Code Combination List on or about October 1, 2017. This update is based on the CARC and RARC updates as posted at the Washington Publishing Company (WPC) website on or about July 1, 2017. This will also include updates based on Market Based Review that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them. See http://www.wpc-edi.com/reference or CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php or CAQH CORE defined code combination updates.

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

Additional Information

The official instruction, CR10140, issued to your MAC regarding this change is available at

https://www.cms.gov/Regulations-andGuidance/Guidance/Transmittals/2017Downloads/R3841CP.pdf.

SPR Suppression in 45 Days if Also Receiving ERA

MLN Matters Number: MM10151
Related Change Request (CR) Number: 10151
Related CR Release Date: August 4, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R1890OTN
Implementation Date: January 2, 2018

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.

Provider Action Needed

Change Request (CR) 10151 provides notice that beginning January 2, 2018, Medicare's Shared System Maintainers (SSMs) must eliminate issuance of Standard Paper Remittance Advice (SPRs) to those providers/suppliers (or a billing agent, clearinghouse, or other entity representing those providers/suppliers) who also have been receiving Electronic Remittance Advice (ERA) transactions for 45 days or more. The shared system changes to suppress the distribution of SPRs were implemented in January 2006 per CR3991 (issued August 12, 2005, Transmittal 645). Make sure your billing staffs are aware of the suppression of the SPR.

Background

The SPR is the hard copy version of an ERA. MACs, including Durable Medical Equipment (DME) MACs must be capable of producing SPRs for providers/suppliers who are unable or choose not to receive an ERA. The MACs and the DME MACs suppress distribution of SPRs if an Electronic Data Interchange (EDI) enrolled provider/supplier is also receiving ERAs for more than 31 days for Institutional Health Care Claims (837I) and 45 days for DME and Professional Health Care Claims (837P). Internet-Only-Manuals (IOMs), MLN Matters Article MM4376 provided information to the MACs regarding the receipt of SPR and ERA distribution time lines.

Beginning February 14, 2018, the SSMs shall suppress the delivery of SPR to the MACs EDI enrolled providers/suppliers who are also receiving both the ERA and SPR. In rare situations (such as natural or man-made disasters) exceptions to this policy may be allowed at the discretion of the Centers for Medicare & Medicaid Services (CMS). MACs will not send a SPR/hard copy version to a particular provider/supplier unless this requirement causes hardship and CMS has approved a waiver requested by your MAC.

Note: MM4376 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4376.pdf.

Additional Information

The official instruction, CR10151, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1890OTN.pdf.

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

MLN Matters® Number: SE1128 Revised

Release Date of Revised Article: August 23, 2017

This article was revised on August 23, 2017, to highlight upcoming system changes that identify the Qualified Medicare Beneficiary (QMB) status of beneficiaries and exemption from Medicare cost-sharing, recommend key ways to promote compliance with QMB billing rules, and remind certain types of providers that they may seek reimbursement for unpaid deductible and coinsurance amounts as a Medicare bad debt.

Provider Types Affected

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

Provider Action Needed

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds all Medicare providers and suppliers that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Look for new information and messages in CMS' HIPAA Eligibility Transaction System (HETS) and the Provider Remittance Advice (RA) to identify patients' QMB status and exemption from cost-sharing prior to billing. If you are an MA provider, contact the MA plan for more information about verifying the QMB status of plan members.

Implement key measures to ensure compliance with QMB billing requirements. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid. For information about obtaining payment for Medicare cost-sharing, contact the Medicaid agency in the States in which you practice. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

Background

All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must refrain from charging individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays. In 2015, 7.2 million individuals (more than one out of 10 beneficiaries) were enrolled in the QMB program. See the chart at the end of this article for more information about the QMB benefit.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Act.)

Note that certain types of providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt discussed in Chapter 3 of the Provider Reimbursement Manual (Pub.15-1).

Refer to the Important Reminders Concerning QMB Billing Requirements Section below for key policy clarifications.

Inappropriate Billing of QMB Individuals Persists

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

Ways to Promote Compliance with QMB Billing Rules

Take the following steps to ensure compliance with QMB billing prohibitions:

1. Establish processes to routinely identify the QMB status of your Medicare patients prior to billing for items and services.

Beginning November 4, 2017, providers and suppliers can use Medicare eligibility data provided to Medicare providers, suppliers, and their authorized billing agents (including clearinghouses and third party vendors) by CMS' HETS to verify a patient's QMB status and exemption from cost-sharing charges. For more information on HETS, see https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.

Starting October 3, 2017, original Medicare providers and suppliers can readily identify the QMB status of patients and billing prohibitions from the Medicare Provider RA, which will contain new notifications and information about a patient's QMB status. Refer to Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System for more information about these improvements.

- MA providers and suppliers should also contact the MA plan to learn the best way to identify the QMB status of plan members.
- Providers and suppliers may also verify a patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid identification cards and documents issued by the State proving the patient is enrolled in the QMB program.

2. Ensure that billing procedures and third-party vendors exempt individuals enrolled in the QMB program from Medicare charges and that you remedy billing problems should they occur. If you have erroneously billed an individual enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges he or she paid.

3. Determine the billing processes that apply to seeking payment for Medicare cost-sharing from the States in which you operate. Different processes may apply to Original Medicare and MA services provided to individuals enrolled in the QMB program. For Original Medicare claims, nearly all States have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

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

Important Reminders Concerning QMB Billing Requirements

Be aware of the following policy clarifications on QMB billing requirements:

1. All original Medicare and MA providers and suppliers–not only those that accept Medicaid–must abide by the billing prohibitions.

2. Individuals enrolled in the QMB program retain their protection from billing when they cross State lines to receive care. Providers and suppliers cannot charge individuals enrolled in QMB even if their QMB benefit is provided by a different State than the State in which care is rendered.

3. Note that individuals enrolled in QMB cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The Federal statute referenced above supersedes Section 3490.14 of the State Medicaid Manual, which is no longer in effect.

QMB Eligibility and Benefits

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

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

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

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

Additional Information

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

Physicians! Are You Ordering Diabetic Shoes for Your Patients? – Revised

This article has been revised as of July 11, 2017.

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

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

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

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

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

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

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

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

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

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

The Certifying Physician must either:

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

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

Just a few reminders:

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

All orders and medical records must meet CMS Signature Requirements.

Following this guidance will help your patients and the Medicare program by verifying there is medical documentation to support the provisions for Therapeutic Shoes for Persons with Diabetes, allow your patients to receive the items needed to treat their diabetic condition, and allow Medicare to pay claims appropriately.

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

Jurisdiction A

Jurisdiction B

Jurisdiction C

Jurisdiction D

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