DME Happenings

Jurisdiction D
Issue 53
December 2016

In This Issue...

FYI

APPEALS

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

Don't be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select "Subscribe" on the bottom right-hand corner of any page.

Noridian Healthcare Solutions, LLC

BILLING

CERT

CODING

COMPETITIVE BIDDING

COVERAGE

DOCUMENTATION

EXTERNAL INFUSION PUMPS

GLUCOSE MONITORS

HOSPITAL BEDS

ICD-10

IMMUNOSUPPRESSIVE DRUGS

LCD AND POLICY ARTICLE REVISIONS

MOBILITY DEVICES

NEBULIZER DRUGS

ORTHOTICS AND PROSTHETICS

OVERPAYMENTS AND REFUNDS

OXYGEN

PAP DEVICES

PRESSURE REDUCING SUPPORT SURFACES

REIMBURSEMENT

THERAPEUTIC SHOES

UPDATES

UROLOGICAL SUPPLIES

Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 am – 8 pm CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status
Supplier Contact Center	1-877-320-0390	8 am – 6 pm CT Monday-Friday
Telephone Reopenings	1-877-320-0390	8 am – 4:30 pm CT
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week

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

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

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

Mailing Addresses	
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian PO Box 6727 Fargo, ND 58108-6727	**Benefit Protection** Noridian Benefit Protection-DME PO Box 6736 Fargo, ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian PO Box 6737 Fargo, ND 58108-6737	**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville, FL 32231-4013
Electronic Funds Transfer Forms/ Overpayment Redeterminations/ DME Recovery Auditor Redeterminations Noridian PO Box 6728 Fargo, ND 58108-6728	**DME Recovery Auditor Overpayments** Noridian PO Box 6759 Fargo, ND 58108-6759

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

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

CMS Quarterly Provider Updates

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

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

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

Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D 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.

Fingerprint-based Background Check Begins August 6, 2014 – Rescinded

MLN Matters® Number: SE1427 Rescinded

This article was rescinded on October 17, 2016. For information on the Fingerprint-based Background Check requirement, view MLN Matters® article SE1417, "Implementation of Fingerprint-Based Background Checks", available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1417.pdf.

ZPICs Transitioning to UPICs – UPIC Midwestern Awarded to AdvanceMed

CMS has awarded the first Unified Program Integrity Contractor (UPIC) jurisdiction, Midwestern, to AdvanceMed, a wholly owned subsidiary of NCI, Inc. The UPIC statement of work combines and integrates the functions of the former Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts into a single contract. UPIC Midwestern Jurisdiction is scheduled to be fully operational on October 20, 2016.

Under this award, AdvanceMed will perform fraud, waste and abuse (FWA) detection and prevention activities for Medicare and Medicaid claims processed within the Midwestern Jurisdiction. This covers the states of Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin.

AdvanceMed will focus on analysis of managed care encounter and fee-for-service claims data, and coordination with appropriate partners for referral and resolution of identified issues for Medicare and Medicaid programs. AdvanceMed's specific work will include lead screening; investigation; medical review; remedy implementation; and collaboration with CMS, federal, state and local government, law enforcement, and other CMS partners and contractors.

Important Reminder – Self-Service Options vs. Calling Contact Center for Claim Inquiries and Beneficiary Eligibility

Noridian is committed to providing superior customer service to our DMEPOS suppliers and want to ensure that our Contact Center Customer Service Representatives (CSRs) are available to assist those callers with complex inquiries which cannot be answered through the Interactive Voice Response (IVR).

CSRs are unable to provide callers with information that is available within the IVR

Per CMS Internet Only Manual Publication 100-09, Chapter 6, Section 50.1, Providers shall be required to use IVRs to access claim status and beneficiary eligibility information.

Callers with inquiries that may be answered using the IVR will be guided back to the IVR

Interactive Voice Response (IVR)

The following can be accessed via the IVR.

- Eligibility
- Appeal Status
- Claim Status
- PMD Par Requests
- Same and Similar HCPCS Lookup
- Provider Enrollment (PECOS ordering/referring physician enrollment inquiry)
- Checks

- Payment Floor
- CMN Status
- Duplicate Remittance Advice (RA)
- PMD Par Requests

If you need help using the IVR, view the guide and conversion tool on the IVR webpage.

Noridian Medicare Portal (NMP)

In addition to the IVR, the NMP provides more opportunities to satisfy supplier's self-service inquiry needs online. The NMP can provide details related to claims and eligibility to appeal submission and status. To find out more and/or to register, see our Noridian Medicare Portal (NMP) webpage.

If your company has not yet registered for NMP, please share this notice with your company official so they may read all about the benefits of joining.

Suppliers will find that the IVR and the Noridian Medicare Portal (NMP) are valuable tools that provide the necessary details to answer most inquiries.

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."

Portal Enhancements Implemented November 4

In response to provider/supplier feedback, the following changes have been made to the Noridian Medicare Portal (NMP), effective November 4, 2016.

Part A and Part B Reason Codes

The applicable reason codes on Part A and Part B Claim Status will display on each claim line. The reason code descriptions are provided below the claim lines. This information assists the provider in understanding why a claim line has been denied.

Clear Beneficiary Details Button

A new button titled Clear Beneficiary Details has been added to the inquiry screens. After an inquiry is successful and results display, users can return to the inquiry page and the beneficiary details will still be populated. If the next inquiry is for a different beneficiary, this button may be used to quickly clear the existing information.

Eligibility Inquiry Requirements Link

Narrative has been added to the Eligibility Inquiry page to indicate the beneficiary details are required per the CMS HIPAA Eligibility Transaction System (HETS) criteria.

Registrations Pending More than 21 Days will be Deleted

After a provider/supplier establishes a username and password, an email is sent which contains a URL that the provider/supplier must click to complete the initial registration process. If that URL is not selected and the registration portion completed in NMP, the system will automatically delete the account on the day 22. A new registration will be required at that time.

Annual Security Awareness Training

On an annual basis, all providers/suppliers within NMP are required to complete the Annual Security Awareness training. Forty-five days prior to the provider/supplier initial created date in NMP, the provider/supplier will be systematically prompted to complete the additional online training. By selecting Accept, the provider/supplier acknowledges the training and will continue into the NMP. If not accepted, the provider/supplier will not be allowed to enter the NMP.

DME Additional Documentation Request (ADR) Option Explanations

On the ADR inquiry page, explanations of the two search options, Request Sent and Response Received/Processing, are now provided.

Part B Full Remittance Advices Display in Descending Order

Part B full remittance advices now display in descending order so the newest remittance advices are at the top of the list.

Please continue to share your suggestions for the portal on the website satisfaction survey each time it is presented during website or portal navigation.

MLN Connects® Provider eNews – September 8, 2016

MLN Connects® Provider eNews for September 8, 2016

View this edition as a PDF

News & Announcements

- EHR Incentive Program 2017 Medicare Payment Adjustment for Hospitals
- IRF and LTCH QRP Provider Preview Reports Available until September 30
- DMEPOS Suppliers: Use Revised CMS-855S Beginning January 1
- DMEPOS Fee Schedule: Corrections to the July 2016 File
- DMEPOS Fee Schedule: Assignment Monitoring Data Posted
- SNF 30-Day Potentially Preventable Readmission Measure – Updated
- 2015 PQRS Feedback Reports and 2015 Annual QRURs: Are You Ready?
- New Look for Think Cultural Health
- Healthy Aging® Month – Discuss Preventive Services with your Patients

Provider Compliance

- Coudé Tip Catheters

Claims, Pricers & Codes

- October 2016 Average Sales Price Files Now Available

Upcoming Events

- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15
- SNF Value-Based Purchasing Program Call – September 28
- 2015 Annual QRURs Webcast – September 29
- Comparative Billing Report on Modifier 25: OB/GYN Webinar – October 5

Medicare Learning Network® Publications & Multimedia

- Advance Care Planning Fact Sheet – New

MLN Connects® Provider eNews – September 15, 2016

MLN Connects® Provider eNews for September 15, 2016

View this edition as a PDF

News & Announcements

- Plans for the Quality Payment Program in 2017: Pick Your Pace
- CMS Finalizes Rule to Bolster Emergency Preparedness of Certain Facilities
- DMEPOS Competitive Bidding Payment Amounts and Contract Offers for Round 1 2017
- New Data: 49 States plus DC Reduce Avoidable Hospital Readmissions
- SNF QRP Provider Training Questions and Feedback on MDS 3.0
- EHR Incentive Programs: Materials from August Webinars Available
- ICD-10 Coordination and Maintenance Committee Meeting: Materials Available
- Track ICD-10 Progress and Manage Your Revenue Cycle

Provider Compliance

- Advanced Life Support Ambulance Services: Insufficient Documentation

Upcoming Events

- SNF Value-Based Purchasing Program Call – September 28
- 2015 Annual QRURs Webcast – September 29
- IMPACT Act: Data Elements and Measure Development Call – October 13

Medicare Learning Network® Publications & Multimedia

- Overview of the SNF Value-Based Purchasing Program MLN Matters® Article – New
- Fee-For-Service Data Collection System: Clinical Laboratory Fee Schedule Data Reporting Template MLN Matters Article – New
- Clinical Laboratory Fee Schedule Fact Sheet – Revised
- ICD-10-CM/PCS Myths and Facts Fact Sheet – Revised
- ICD-10-CM Classification Enhancements Fact Sheet – Revised
- ICD-10-CM/PCS The Next Generation of Coding Fact Sheet – Revised
- General Equivalence Mappings Frequently Asked Questions Booklet – Revised
- Quick Reference Chart: Descriptors of G-codes and Modifiers for Therapy Functional Reporting Educational Tool – Revised
- Preventive Services Educational Tool – Reminder

MLN Connects® Provider eNews – September 22, 2016

MLN Connects® Provider eNews for Thursday, September 22, 2016

View this edition as a PDF

News & Announcements

- Revised CMS-855R Application Available: Reassignment of Medicare Benefits
- IRF and LTCH QRP Provider Preview Reports – Review Your Data by September 30
- eCQI Resource Center has News and Resources

Compliance

- Reporting Changes in Ownership

Events

- SNF Value-Based Purchasing Program Call – September 28
- 2015 Annual QRURs Webcast – September 29
- Emergency Preparedness Requirements Call – October 5
- IMPACT Act: Data Elements and Measure Development Call – October 13
- Comparative Billing Report on CMT of the Spine Webinar – October 19

Learning Network® Publications & Multimedia

- Fee-For-Service Data Collection System: CLFS Data Reporting Template MLN Matters® Article – Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Web-Based Training – Revised
- Transitional Care Management Services Fact Sheet – Revised
- Federally Qualified Health Center Fact Sheet – Revised
- Health Professional Shortage Area Physician Bonus Program Fact Sheet – Revised
- Hospital Outpatient Prospective Payment System Fact Sheet – Revised
- Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Fact Sheet – Revised
- Medicare Ambulance Transports Booklet – Revised
- Acute Care Hospital Inpatient Prospective Payment System Booklet – Revised
- Critical Access Hospital Booklet – Revised

MLN Connects® Provider eNews – September 29, 2016

MLN Connects® Provider eNews for Thursday, September 29, 2016

View this edition as a PDF

Editor's Note:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. In this issue, learn about the new Medicare Beneficiary Identifier, and find out how to prepare.

News & Announcements

- Social Security Number Removal Initiative
- 2015 PQRS Feedback Reports and 2015 Annual QRURs Available
- IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
- New CERT Documentation Contractor Effective October 14
- Medicare EHR Requirements for 2016 Participation
- EHR Incentive Programs: 2016 Exclusions and Alternate Exclusions
- eCQM: Review and Comment on Proposed Specification Changes
- Updated ICD-10 Flexibility FAQs and 2017 Codes
- Medscape Article for CME Credit: Transforming Clinical Practice to Provide Patient-Centered Quality Care
- National Cholesterol Education Month and World Heart Day

Provider Compliance
- Evaluation and Management: Billing the Correct Level of Service

Claims, Pricers & Codes
- Hospices: Hold on Claim Adjustments for Miscounted Routine Home Care Days

Upcoming Events
- Emergency Preparedness Requirements Call – October 5
- IMPACT Act: Data Elements and Measure Development Call – October 13
- How to Report Across 2016 Medicare Quality Programs Call – November 1

Medicare Learning Network® Publications & Multimedia
- SNF Quality Reporting Program Webcast: Audio Recording and Transcript – New
- Dementia Care and QAPI Call: Audio Recording and Transcript – New
- PQRS Call Addendum – New
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet – Revised
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet – Revised
- Medicare Enrollment for Institutional Providers Fact Sheet – Revised
- Safeguard Your Identity and Privacy Using PECOS Fact Sheet – Revised
- Revised "How to" Products Available in Hard Copy Format

MLN Connects® Provider eNews – October 6, 2016

MLN Connects® Provider eNews for Thursday, October 6, 2016

View this edition as a PDF

News & Announcements
- CMS Finalizes Improvements in Care, Safety, and Consumer Protections for Long-Term Care Facility Residents
- CMS Awards $347 Million to Continue Progress toward a Safer Health Care System
- HH Quality of Patient Care Star Ratings and HH Compare Preview Reports Available
- New Electronic Appeals System: MOD E-File Available
- New EHR Contract Guide and Health IT Playbook
- EHR Incentive Programs: Learn About Important Changes
- EHR Incentive Programs: 2016 CQM Requirements
- October is National Breast Cancer Awareness Month

Provider Compliance
- Automatic External Defibrillators: Inadequate Medical Record Documentation

Claims, Pricers & Codes
- Billing for Influenza: New CPT Code 90674

Upcoming Events
- IMPACT Act: Data Elements and Measure Development Call – October 13
- Physician Compare Public Reporting Information Sessions – October 18 and 19
- 2015 Supplemental QRUR Physician Feedback Program Call – October 20

- Long-Term Care Facilities: Reform of Requirements Call – October 27
- How to Report Across 2016 Medicare Quality Programs Call – November 1

Medicare Learning Network® Publications & Multimedia

- Medicare Part B Drug Average Sales Price Reporting by Manufacturers – Blending National Drug Codes MLN Matters® Article – New
- Medicare Parts A & B Appeals Process Booklet – Revised
- Resources for Medicare Beneficiaries Booklet – Revised

MLN Connects® Provider eNews – October 13, 2016

MLN Connects® Provider eNews for Thursday, October 13, 2016

View this edition as a PDF

News & Announcements

- New Data to Increase Transparency on Medicare Hospice Payments
- SNF Value-Based Purchasing Program: Confidential Feedback Reports Available
- IMPACT Act Cross-Setting Quality Measure on Major Falls: Comments due October 14
- EHR Incentive Programs: Review Resources on 2016 Program Requirements
- Protect Your Patients from Influenza this Season

Provider Compliance

- Reporting Fraud to the Office of the Inspector General

Upcoming Events

- CMS Rural Health Council Solutions Summit – October 19
- 2015 Supplemental QRUR Physician Feedback Program Call – October 20
- Long-Term Care Facilities: Reform of Requirements Call – October 27
- How to Report Across 2016 Medicare Quality Programs Call – November 1
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call – November 2

Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter Educational Tool – New
- Learning Management and Product Ordering System FAQs Booklet – New
- SNF Value-Based Purchasing Program Call: Audio Recording and Transcript – New
- 2015 Annual QRURs Webcast: Audio Recording and Transcript – New
- Medicare Basics: Commonly Used Acronyms Educational Tool – Revised
- Preventive Services Educational Tool – Revised
- Fraud & Abuse Educational Products – Revised
- Screening Pap Tests and Pelvic Examinations Booklet – Reminder
- Give us Your Feedback

MLN Connects® Provider eNews Special Edition – October 14, 2016

CMS Finalizes the New Medicare Quality Payment Program

On October 14, HHS finalized its policy implementing the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) incentive payment provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), collectively referred to as the Quality Payment Program. The new Quality Payment Program will gradually transform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care system.

The final rule with comment period offers a fresh start for Medicare by centering payments around the care that is best for the patients, providing more options to clinicians for innovative care and payment approaches, and reducing administrative burden to give clinicians more time to spend with their patients, instead of on paperwork.

Accompanying the announcement is a new Quality Payment Program website, which will explain the new program and help clinicians easily identify the measures most meaningful to their practice or specialty.

For More Information:

- Final Rule and Executive Summary
- Press Release
- Fact Sheet
- Quality Payment Program website

MLN Connects® Provider eNews – October 20, 2016

MLN Connects® Provider eNews for Thursday, October 20, 2016

View this edition as a PDF

News & Announcements

- CMS Announces New Initiative to Increase Clinician Engagement
- Medicare's Investment in Primary Care Shows Progress
- Physician Compare Preview Period Ends November 11
- Value Modifier: Informal Review Request Period Open through November 30
- 2015 Supplemental Quality and Resource Use Reports Available
- Medicare Open Enrollment Information for your Patients

Provider Compliance

- Importance of Documentation

Claims, Pricers & Codes

- October 2016 OPPS Pricer File Update

Upcoming Events

- Long-Term Care Facilities: Reform of Requirements Call – October 27
- How to Report Across 2016 Medicare Quality Programs Call – November 1
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call – November 2
- Quality Payment Program Final Rule Call – November 15
- Home Health Quality Reporting Program Provider Training – November 16 and 17

Medicare Learning Network® Publications & Multimedia

- Provider Compliance Fact Sheets – New
- Emergency Preparedness Requirements Call: Audio Recording and Transcript – New
- Evaluation and Management Services Guide – Revised
- Hospice Payment System Booklet – Revised
- Provider Compliance Fact Sheets – Revised
- Continuing Education Credits for Web-Based Training Courses

MLN Connects® Provider eNews – October 27, 2016

MLN Connects® Provider eNews for Thursday, October 27, 2016

View this edition as a PDF

News & Announcements

- Quality Payment Program: Additional Opportunities for Clinicians to Join Innovative Care Approaches
- Hospital Compare Updated with VA Hospital Performance Data
- CMS Awards Special Innovation Projects to QIN-QIOs
- Meeting the Health Challenges of Rural America
- IRF and LTCH Quality Reporting Program Data Submission Deadline: November 15
- Revised Home Health Change of Care Notice: Effective January 17, 2017
- Prepare for ESRD QIP PY 2017 Reporting Documents by Updating your Account
- Technical Update to 2016 QRDA I Schematrons for eCQM Reporting
- Check Your Patients Addresses
- Connect with Us on LinkedIn

Provider Compliance

- Duplicate Claims

Upcoming Events

- Social Security Removal Initiative Open Door Forum– November 1
- How to Report Across 2016 Medicare Quality Programs Call – November 1
- Comparative Billing Report on Subsequent Hospital Care Webinar – November 2
- Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call – November 2
- Solutions to Reduce Disparities Webinar – November 14
- Quality Payment Program Final Rule Call – November 15

Medicare Learning Network® Publications & Multimedia

- Implementation of LTCH PPS Based on Specific Clinical Criteria MLN Matters® Article –New
- Provider Compliance Fact Sheets – New
- IMPACT Act Call: Audio Recording and Transcript – New
- PECOS FAQs Fact Sheet – Revised
- DMEPOS Information for Pharmacies Fact Sheet – Revised
- Complying with Documentation Requirements for Laboratory Services Fact Sheet – Reminder
- Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet – Reminder

MLN Connects® Provider eNews – November 3, 2016

MLN Connects® Provider eNews for Thursday, November 3, 2016

View this edition as a PDF

News & Announcements

- Updates to Dialysis Facility Compare: Patient Experience Ratings Available
- Hospital Value-Based Purchasing Program Results for FY 2017
- DMEPOS Competitive Bidding Program: CMS Awards Contracts for Round 1 2017
- 2017 PQRS Results: Submit an Informal Review by November 30
- IRF and LTCH Quality Reporting Program: NHSN Rebaseline Guidance
- Recovery Audit Contractor Awards
- Antipsychotic Drug use in Nursing Homes: Trend Update
- November is Home Care and Hospice Month

Provider Compliance

- Chiropractic Services: High Part B Improper Payment Rate

Claims, Pricers & Codes

- Billing for Influenza: New CPT Code 90674

Upcoming Events

- Quality Payment Program Final Rule Call – November 15
- 2016 Hospital Appeals Settlement Call – November 16
- IRF and LTCH: Transition to NHSN Rebaseline Webinar – November 16
- IRF and LTCH Quality Measure Report Call – December 1
- National Partnership to Improve Dementia Care and QAPI Call – December 6
- CMS 2016 Quality Conference – December 13-15

Medicare Learning Network® Publications & Multimedia

- Provider Compliance Fact Sheets – New
- QRUR Call: Audio Recording and Transcript – New
- Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet – Revised

MLN Connects® Provider eNews – November 10, 2016

MLN Connects® Provider eNews for Thursday, November 10, 2016

View this edition as a PDF

News & Announcements

- Proposed Rule on Fire Safety Requirements for Applicable Dialysis Facilities
- IMPACT Act Cross-Setting Quality Measure on Pressure Ulcers: Comments due November 17
- 2017 PQRS Results: Submit an Informal Review by November 30
- Value Modifier: Informal Review Request Period Open through November 30
- IRF-PAI and LTCH Provider Reports Retention Change: Take Action by December 1
- Open Payments: Physicians and Teaching Hospitals Review Pubic Data by December 31

- Quality Payment Program Presentations Available
- New Guide Helps Nursing Homes Tackle Antimicrobial Stewardship
- Raising Awareness of Diabetes in November

Provider Compliance

- Compliance Program Basics

Claims, Pricers & Codes

- Re-release of V34 ICD-10 MS-DRG Grouper, Definitions Manual, and Errata Available

Upcoming Events

- Quality Payment Program Final Rule Call – November 15
- 2016 Hospital Appeals Settlement Call – November 16
- Medicare Diabetes Prevention Program Model Expansion Call – November 30
- IRF and LTCH Quality Measure Report Call – December 1
- National Partnership to Improve Dementia Care and QAPI Call – December 6

Medicare Learning Network® Publications & Multimedia

- Inappropriate Billing of Qualified Medicare Beneficiaries MLN Matters® Article – New
- Long-Term Care Call: Audio Recording and Transcript – New
- PECOS for Physicians and Non-Physician Practitioners Fact Sheet – Revised
- Power Mobility Devices Fact Sheet – Revised
- IMPACT Act Videos – Reminder

MLN Connects® Provider eNews – November 17, 2016

MLN Connects® Provider eNews for Thursday, November 17, 2016

View this edition as a PDF

News & Announcements

- CMS and Indian Health Service Expand Collaboration to Improve Health Care in Hospitals
- CMS to Release a Comparative Billing Report on Knee Orthoses in January
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

Provider Compliance

- False Claims Act

Claims, Pricers & Codes

- Sunsetting of Section 1011: Emergency Health Services Furnished to Undocumented Aliens
- LTCH: Clarification of Immediately Preceding Hospitals for Exclusion from Site Neutral Payment Rate

Upcoming Events

- Medicare Diabetes Prevention Program Model Expansion Call – November 30
- IRF and LTCH Quality Measure Report Call – December 1
- National Partnership to Improve Dementia Care and QAPI Call – December 6
- 2016 Hospital Appeals Settlement Update Call – December 12
- Comparative Billing Report on Viscosupplementation of the Knee Webinar – December 14

Medicare Learning Network® Publications & Multimedia

- Hard Copy Claims Not Crossing Over Due to Duplicate Diagnosis Codes MLN Matters Article – New
- Medicare Basics: Parts A and B Claims Overview Video – New
- Medicare Quality Programs Call: Audio Recording and Transcript – New
- Clinical Labs Call: Audio Recording and Transcript – New
- Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet – Revised

MLN Connects® Provider eNews – November 23, 2016

MLN Connects® Provider eNews for Wednesday, November 23, 2016

View this edition as a PDF

News & Announcements

- CMS Launches New Online Tool to Make Quality Payment Program Easier for Clinicians
- 2017 PQRS Results: Submit an Informal Review by November 30
- Value Modifier: Informal Review Request Period Open through November 30
- IMPACT Act Cross-Setting Quality Measures: Comments Due
- Post-Acute Care QRP Data Submission Exceptions for Hurricane Matthew
- New Quality Payment Program Resources Available
- Each Office Visit is an Opportunity to Recommend Influenza Vaccination

Provider Compliance

- Enteral Infusion Pumps

Claims, Pricers & Codes

- Reprocessing of Some IPPS Claims

Upcoming Events

- Medicare Diabetes Prevention Program Model Expansion Call – November 30
- IRF and LTCH Quality Measure Report Call – December 1
- National Partnership to Improve Dementia Care and QAPI Call – December 6
- 2016 Hospital Appeals Settlement Update Call – December 12
- IRF-PAI Therapy Information Data Collection Call – January 12

Medicare Learning Network® Publications & Multimedia

- Emergency Preparedness Video Presentation – New
- Inappropriate Billing of Qualified Medicare Beneficiaries for Medicare Cost-Sharing MLN Matters Article – Revised
- Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs MLN Matters Article – Revised
- Hospital-Acquired Conditions and POA Indicator Reporting Provision Fact Sheet – Reminder
- PAP Devices: Complying with Documentation & Coverage Requirements Fact Sheet – Revised
- Evaluation and Management Services Guide – Reminder
- DMEPOS Quality Standards Booklet–Revised
- Medicare Claim Review Programs Booklet – Revised
- Drug Diversion: Do You Know Where the Drugs Are Going? Web-Based Training Course–Revised
- Hospice Payment System Booklet – Reminder

MLN Connects® Provider eNews Special Edition – November 28, 2016

80% Favorable Outcomes for Suppliers Participating in DME Medicare Appeals Demonstration

Durable Medical Equipment (DME) suppliers in Jurisdictions C and D have the opportunity to participate in the Formal Telephone Discussion and Reopenings Demonstration. Suppliers that submit second level appeal requests have the opportunity to participate in formal recorded telephone discussions with the DME Qualified Independent Contractor to present the facts of their cases and provide additional documentation that would support a favorable determination. Preliminary data indicates that reconsiderations completed under the demonstration resulted in approximately 80% favorable outcomes for suppliers who participated in a discussion, twice the level experienced by suppliers who declined to participate. Recent changes to the demonstration:

- Now includes all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claim types
- Removes the five claims per National Provider Identifier (NPI) limit
- Removes the requirement that a formal telephone discussion occur before a reopening can be offered

See the fact sheet, and visit the Formal Telephone Discussion Demonstration webpage for more information.

MLN Connects® Provider eNews – December 1, 2016

MLN Connects® Provider eNews for Thursday, December 1, 2016

View this edition as a PDF

News & Announcements

- CMS Finalizes Measures under Consideration List for Pre-rulemaking
- Working to Achieve Health Equity: The CMS Equity Plan for Medicare One Year Later
- Clinical Laboratories: Prepare Now to Report Lab Data January 1 – March 31, 2017
- Value Modifier: Informal Review Request Period Extended to December 7
- World AIDS Day is December 1
- National Handwashing Awareness Week: December 4 through 10

Provider Compliance

- Billing For Stem Cell Transplants

Upcoming Events

- National Partnership to Improve Dementia Care and QAPI Call – December 6
- 2016 Hospital Appeals Settlement Update Call – December 12
- IRF-PAI Therapy Information Data Collection Call – January 12

Medicare Learning Network® Publications & Multimedia

- Documentation Requirements for the Hospice Physician Certification/Recertification MLN Matters Article – New
- Sample Hospice Notice of Election Statement MLN Matters Article – New
- Quality Payment Program Call: Audio Recording and Transcript – New
- Hospital Appeals Settlement Call: Audio Recording and Transcript – New

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 • KJ • NU • KL • LT
	  • KI • RR • AU • RT
	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. Please see the article posted March 21, 2013
	• Oxygen break in service (BIS) issues
	• Some manual wheelchairs and all power mobility devices (PMDs) – HCPCS K0005 and higher
	• Overpayments or reductions in payment
	• Medicare Secondary Payer (MSP) issues
	• Claims denied for timely filing
	• Reopenings past one year from the initial determination
	• Complex Medical Reviews or Additional Documentation Requests
	• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues
	• Repair and labor claims
	• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing
	• The following modifier changes or additions:
	  • A1 through A9 • GA • GZ • EY • RA • RP
	  • K0 through K4 • GY • KX • KG • RB
	• Certain HCPCS codes (not all-inclusive list)
	  • A4450 through A4452 • J1559
	  • E0194 • J1561
	  • E0748 • J1562
	  • K0462 • K0108
	  • E1028

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

APPEALS

ALJ and Federal District Court Amount in Controversy Increase for 2017

Section 1869(b)(1)(E) of the Social Security Act, as amended by Section 940 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), requires an annual reevaluation of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing and for Federal District Court review. The amount in controversy is adjusted by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved.

The amount that must remain in controversy for review for an ALJ hearing requested on or before December 31, 2015, is $150. This amount will increase to $160 for ALJ hearing requests filed on or after January 1, 2017. The amount that must remain in controversy for reviews in Federal District Court requested on or before December 31, 2016 is $1,500. This amount will increase to $1,560 for appeals to Federal District Court filed on or after January 1, 2017.

Redetermination and Written Reopening Submission Available through NMP

Noridian encourages suppliers to use the Noridian Medicare Portal (NMP) to submit redeterminations to streamline office operations.

Take advantage of this self-service tool to eliminate time-consuming faxing or hardcopy mailing. The portal is easy to use and allows suppliers to attach all supporting documentation electronically. Another plus is the real time confirmation number; no more calling the Interactive Voice Response (IVR) to confirm receipt!

Visit our Noridian Medicare Portal today to learn more. If a supplier's company has not yet enrolled in the Noridian Medicare Portal, please share this notice with the company official so the organization can learn about all the benefits of joining. The instructions for joining the Noridian Medicare portal are detailed on our website.

BILLING

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

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

HCPCS Code	Descriptor
97161	PT EVAL LOW COMPLEX 20 MIN
97162	PT EVAL MOD COMPLEX 30 MIN
97163	PT EVAL HIGH COMPLEX 45 MIN
97164	PT RE-EVAL EST PLAN CARE
97165	OT EVAL LOW COMPLEX 30 MIN
97166	OT EVAL MOD COMPLEX 45 MIN
97177	OT EVAL HIGH COMPLEX 60 MIN
97168	OT RE-EVAL EST PLAN CARE

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

Additional Information

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

Issuing Compliance Letters to Specific Providers and Suppliers Regarding Inappropriate Billing of QMBs for Medicare Cost-Sharing – Revised

MLN Matters® Number: MM9817 Revised
Related Change Request (CR) #: CR 9817
Related CR Release Date: November 18, 2016
Effective Date: December 16, 2016
Related CR Transmittal #: R17570TN
Implementation Date: March 8, 2017

This article was revised on November 18, 2016, to reflect the revised CR9817 issued that same day. In the article, the effective date, CR release date, transmittal number, and the Web address for CR9817 are revised. The sample letters at the end of the article have slight wording changes to show that the Medicaid program also helps low-income beneficiaries pay their Medicare premiums. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Federal law bars Medicare providers from charging individuals enrolled in the Qualified Medicare Beneficiary Program (QMB) for Medicare Part A and B deductibles, coinsurances, or copays. QMB is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Change Request (CR) 9817 instructs MACs to issue a compliance letter instructing named providers and suppliers to refund any erroneous charges and recall any past or existing billing with regard to improper QMB billing. Please make sure your billing staffs are aware of this aspect of your Medicare provider agreement.

Background

In 2013, approximately seven million Medicare beneficiaries were enrolled in QMB, a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost sharing.

State Medicaid programs are liable to pay Medicare providers who serve QMB individuals for the Medicare cost sharing. However, federal law permits states to limit provider payment for Medicare cost sharing to the lesser of the Medicare cost sharing amount, or the difference between the Medicare payment and the Medicaid rate for the service provided. Regardless, Medicare providers must accept the Medicare payment and Medicaid payment (if any, and including any permissible Medicaid cost sharing from the beneficiary) as payment in full for services rendered to a QMB individual.

Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions, as described in Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); and 1848(g)(3) of the Social Security Act (the Act).

In July 2015, the Centers for Medicare & Medicaid Services issued a study finding that:

- Erroneous billing of QMB individuals persists
- Confusion about billing rules exists amongst providers and beneficiaries

Note: The study, titled "Access to Care Issues Among Qualified Medicare Beneficiaries (QMB)," is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

In September 2016, all Medicare beneficiaries received "Medicare & You 2017," which contains new language to advise QMB individuals about their billing protections. Also, a toll-free number (1-800-MEDICARE) is available to QMB individuals if they cannot resolve billing problems with their providers. In addition, effective September 17, 2016, Beneficiary Contact Center (BCC) Customer Service Representatives (CSRs) can identify a caller's QMB status and advise them about their billing rights.

BCC CSRs will begin escalating beneficiary inquiries involving QMB billing problems that the beneficiary has been unable to resolve with the provider to the appropriate MAC. MACs will issue a compliance letter for all inquiries referred. This compliance letter will instruct named providers and suppliers to refund any erroneous charges and recall any past or existing QMB billing (including referrals to collection agencies).

MACs will also send a copy of the compliance letter to the named beneficiary, with a cover letter advising the beneficiary to show the mailing to the named provider and verify that the provider corrected the billing problem. Examples of these letters are included following the "Document History" section of this article.

Additional Information

The official instruction, CR9817, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1757OTN.pdf.

Example of Cover Letter for affected QMB Individuals sent by MAC:

[month] [day], [year]

[address]

[City] ST [Zip]

Reference ID: (NPI, etc.)

Dear [Beneficiary Name]:

You contacted Medicare about a bill you got from [Provider/Supplier Name]. Then we sent [Provider/Supplier Name] the letter on the next page.

You are in the Qualified Medicare Beneficiary (QMB) program. It helps pay your Medicare premiums and costs. Medicare providers cannot bill you for Medicare deductibles, coinsurance, or copays for covered items and services.

The letter tells the provider to stop billing you and to refund you any amounts you already paid. Here's what you can do:

- Show this letter to your provider to make sure they fixed your bill.
- Tell all of your providers and suppliers you are in the QMB program.
- Show your Medicare and your Medicaid or QMB cards each time you get items or services.

If you have questions about this letter, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

Sincerely,

[Name]

[Title]

[MAC name]

Example of Compliance Letter Sent to Provider by the MAC:

[month] [day], [year]

[address]

[City] ST [Zip]

Reference ID: (NPI, etc.)

Dear [Provider/Supplier Name]:

The Centers for Medicare & Medicaid Services (CMS) received information that [Provider/Supplier Name] is improperly billing [Medicare beneficiary name/HICN number] for Medicare cost-sharing.

This beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program, a state Medicaid program that helps low-income beneficiaries pay their Medicare premiums and cost-sharing. Federal law says Medicare providers can't charge individuals enrolled in the QMB program for Medicare Part A and B deductibles, coinsurances, or copays for items and services Medicare covers.

- Promptly review your records for efforts to collect Medicare cost-sharing from [Medicare beneficiary name/HICN number], refund any amounts already paid, and recall any past or existing billing (including referrals to collection agencies) for Medicare-covered items and services
- Ensure that your administrative staff and billing software exempt individuals enrolled in the QMB program from all Medicare cost-sharing billing and related collection efforts

Medicare providers must accept Medicare payment and Medicaid payment (if any) as payment in full for services given to individuals enrolled in the QMB program. Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3); 1905(p); 1866(a)(1)(A); 1848(g)(3) of the Social Security Act.)

Finally, please refer to this Medicare Learning Network (MLN) Matters® article for more information on the prohibited billing of QMBs: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf. If you have questions, please contact [MAC information].

Sincerely,

[Name]

[Title]

[MAC name]

Guidance to Physician/Practitioner and Supplier Billing Offices that Submit Hard Copy Claims to Medicare to Help Reduce Incidence of Claims Not Crossing Over Due to Duplicate Diagnosis Codes and Diagnosis Code Pointers

MLN Matters® Number: SE1629

Article Release Date: November 8, 2016

Provider Types Affected

This MLN Matters Special Edition (SE) Article is intended for physician/practitioner and supplier billing offices mailing CMS-1500 claim forms to Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article instructs physician/practitioner and supplier billing offices to correctly submit CMS-1500 claim forms to reduce the number of claims that are not "crossed over," or transferred electronically to the destination supplemental payer. Make sure your billing staff is aware of this guidance.

Background

Currently, when physician/practitioner and supplier billing offices mail CMS-1500 claim forms to their MAC or DME MAC, the MAC or DME MAC's shared system uses the resulting adjudication data in the creation of outbound Medicare crossover claims. More specifically, Medicare uses the results from the processing of the incoming hard copy claims to create outbound Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12-N 837 professional Coordination of Benefits (COB) claims.

After the incoming hard-copy claims have met their Medicare payment floor requirements, MACs and DME MACs then transfer these claims to the Centers for Medicare & Medicaid Services (CMS) Benefits Coordination & Recovery Center (BCRC). The BCRC administers CMS' Medicare claims crossover process.

Upon receipt at the BCRC, the claims are edited for HIPAA ASC X12-N 837 claims compliance. Claims that pass compliance are "crossed over," or transferred electronically, to the destination supplemental payer. Claims that fail HIPAA compliance are not crossed over. Instead, the BCRC submits an electronic report to the associated MAC or DME MAC advising why the claims were not crossed over. MACs and DME MACs then create a notification letter that is mailed to the physician/practitioner or supplier's correspondence address of record, which is on file with the MAC or DME MAC. It is within the context of this process that CMS is creating SE1629.

Diagnosis Coding on Claims and Processing and Editing of Those Claims

Beginning in October 2015, billing vendors for physicians and medical practitioners and suppliers in the healthcare industry have been including International Classification of Diseases, Clinical Modifications, Version 10 (ICD-CM-10), on healthcare claims submitted to Medicare in association with specified Service-From Date requirements.

- **Example:** If a claim's Service-From Date is October 15, 2015, physicians/practitioners and suppliers are to bill the claim to Medicare using an ICD-10, rather than ICD-9, diagnosis code.

CMS MACs and DME MACs have either a front-end Contractor Common Edits Module (CCEM) or Common Electronic Data Interchange (CEDI) module that activates when ICD diagnosis code versions are incorrectly used for claim service dates. Additionally, the MAC and DME MAC CCEM and CEDI have logic that activates when incoming electronically- submitted claims contain duplicate ICD-10 diagnosis codes, as well as duplicate diagnosis code pointers.

MACs and DME MACs currently do not have established Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that may be used through Medicare's unprocessable claims procedure to advise physician/practitioners or suppliers that they have either incorrectly:

1. Included a duplicate ICD-10 diagnosis code on an incoming CMS-1500 Claim; or
2. Included a diagnosis code pointer reference more than once (for example, "1, 1") on such claims.

CMS is providing the informational guidance to physicians/practitioners and medical suppliers in the hopes that they will have fewer issues with Medicare crossing their claims over to supplemental payers.

BCRC Editing and Claims Failing to Cross Over

Prior to and after the implementation of ICD-10 diagnosis reporting in October 2015, representatives from the Medicare supplemental payer community informed CMS and its BCRC that the ICD-10-CM, Version 5010 Manual provides direction to users regarding the inappropriateness of reporting ICD-10-CM diagnosis codes more than once. The guidance is as follows:

Within Section B, "General Coding Guidelines, number 12, page 19," the Manual states, "12. Reporting Same Diagnosis Code More Than Once: Each unique ICD-10-CM diagnosis code may be reported only once per encounter. This also applies to bilateral conditions when there are no distinct codes identifying laterally or two different conditions classified to the same ICD-10-CM diagnosis code."

CMS has determined that the above guidance has influenced many healthcare plans, payers, and clearinghouses to create edits that will activate if the same ICD-10 diagnosis code is duplicated on claims. The BCRC, at the discretion of CMS, has also done so, to ensure that supplemental payers will not reject Medicare crossover claims with this characteristic upon receipt. Therefore, any claims that MACs and DME MACs transmit to the BCRC that contain duplicate ICD-10 diagnosis codes are encountering the following error:

- H54271 – "ICD-10 codes cannot be duplicated."

Since MACs and DME MACs have duplicate diagnosis code editing included in their CCEM or CEDI front-end editing routines, incoming electronic HIPAA ASC X12-N 837 claims with these characteristics are being rejected through Medicare's 277-CA process. This means it is primarily incoming hard copy (CMS-1500) claims that are now encountering the H54271 edit rejection.

Additionally, guidance in the HIPAA Technical Report Version 3 (TR-3) Guide governing 837 professional claims transactions makes reference to use of distinct diagnosis pointers to differentiate among multiple diagnosis codes when included on healthcare claims. It appears Medicare's CCEM or CEDI routines catch situations where diagnosis code pointer references are used more than once. However, there is no available CARC or RARC that can be used to identify this situation as part of Medicare's unprocessable claims procedure. Because of this, claims where a diagnosis pointer reference is duplicated, such as "1, 1," are encountering the following error at the BCRC:

- H25670 – "Diagnosis code pointers should not be duplicated."

Next Steps to Remediate This Issue

CMS recognizes it is possible for a physician/practitioner or supplier to reference a given reported diagnosis code, through a diagnosis code pointer, more than once when billing Medicare for multiple services on the same claim. However, vendors or physician/practitioner and supplier offices that create CMS-1500 claims can obtain better Medicare claims crossover results if they:

- Cease reporting the same ICD-9 or ICD-10 diagnosis more than once and
- Cease reporting a diagnosis code pointer reference more than once (for example, 1, 1, or 2, 2)

Additional Information

If you have any questions, please contact your MAC at its toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Date of Service for Pre-Discharge Delivery of DMEPOS

DMEPOS item may be delivered to the beneficiary's home or to the beneficiary in a hospital or a skilled nursing facility for training and fitting purposes, two days prior to the anticipated discharge date. When this occurs, the Date of Service (DOS) on the claim must be the discharge date, although the item is not actually delivered on the discharge date. The Place of Service (POS) billed on the claim must reflect where the beneficiary will be using the DMEPOS item, which would be POS 12 for home. Suppliers should verify the discharge date, prior to billing.

In circumstances where the anticipated discharge date is extended, a narrative should be added to the claim to indicate the extended stay and the reason for the extension. The date of service must be the actual discharge date.

For additional information, view the CMS Internet Only Manual, Publication 100-4, Medicare Claims Processing, Chapter 20, Section 110.3.2.

CERT Documentation

This article is to remind suppliers they must comply with requests from the CERT Documentation Contractor for medical records needed for the Comprehensive Error Rate Testing 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 (240) 568-6222.

Mail all requested documentation to:

CERT Documentation Office
Attn: CID #:xxxxxx
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

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

Suppliers may call the CERT Documentation Contractor at (301) 957-2380 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.

CERT RC Contract Awarded

On August 16, 2016, the CMS awarded the Comprehensive Error Rate Testing (CERT) Review Contractor (RC) work to AdvanceMed, an NCI company. This new contract eliminates the current CERT Documentation Contractor (DC), Livanta, as of October 13, 2016. The work that is currently being performed by the incumbent DC will be transitioned to the RC and fully operational on October 14, 2016.

Important information for this transition is as follows:

- October 6, 2016 is the last day that the current CERT DC will be receiving medical records and CERT inquiries at their location
- Beginning with October 7, 2016, all CERT inquiries and medical records should be addressed to the new contact information provided below

Contact Information

Method	Prior to October 7, 2016	Effective October 7, 2016 and After
Mailing Address	CERT – DC Operations 9090 Junction Dr. Suite 9 Annapolis Junction, MD 20701	CERT Documentation Center 1510 East Parham Road Henrico, VA 23228
Fax	240-568-6222	804-261-8100
Phone Number	301-957-2380	443-663-2699
Toll Free Phone Number	888-779-7477	888-779-7477
Email	CERTMail@livanta.com	CERTMail@admedcorp.com

If documentation is sent to Livanta on/after October 14, 2016, it will be processed as indicated below.

Method	Processing
Fax	Fax will fail
USPS ground mail	Forwarded for six months
Overnight mail	Returned to sender
USPS	Returned to sender
FedEx	Returned to sender

CERT Provider Website

The current CERT Provider Website will remain at the same; however, it will be temporarily unavailable for address updates from October 6-13, 2016. Point of Contact (POC) information will not need to be re-entered if previously submitted to this website.

To ensure the correct individual, or department, is in receipt of CERT requests for documentation and CERT Findings Letters, we (Noridian) encourage providers to review their POC information on/after October 14, 2016.

Please send any inquiries to the appropriate email address below.

Line of Business	Email Address
Part A	CERTPartAQuestion@noridian.com
Part B	CERTQuestion@noridian.com
DME JA	JADMECERT@noridian.com
DME JD	JDDMECERT@noridian.com

New Physician Specialty Code for Hospitalist – Revised

MLN Matters® Number: MM9716 Revised
Related Change Request (CR) #: CR 9716
Related CR Release Date: November 25, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3637CP and R276FM
Implementation Date: April 3, 2017

This article was updated on November 28, 2016, to reflect a revised CR9716, issued on November 25. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9716 announces that the Centers for Medicare & Medicaid Services (CMS) has established a new physician specialty code for Hospitalist. The new code for Hospitalist is C6. Make sure your billing staffs are aware of this physician specialty code.

Background

When they enroll in the Medicare program, physicians self-designate their Medicare physician specialty on the Medicare enrollment application (CMS-855I or CMS-855O), or in the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS uses these Medicare physician specialty codes, which describe the specific/unique types of medicine that physicians (and certain other suppliers) practice, for programmatic and claims processing purposes.

Medicare will also recognize the new code of C6 as a valid specialty for the following edits:

- Ordering/certifying Part B clinical laboratory and imaging, durable medical equipment (DME), and Part A home health agency (HHA) claims
- Critical Access Hospital (CAH) Method II Attending and Rendering claims
- Attending, operating, or other physician or non-physician practitioner listed on CAH claims

Additional Information

The official instruction, CR9716, issued to your MAC regarding this change consists of two transmittals. The first updates the "Medicare Claims Processing Manual" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3637CP.pdf. The second updates the "Medicare /Financial Management Manual" at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R276FM.pdf.

New POS Code for Telehealth and Distant Site Payment Policy

MLN Matters® Number: MM9726
Related Change Request (CR) #: CR 9726
Related CR Release Date: August 12, 2016
Effective Date: January 1, 2017
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Related CR Transmittal #: R3586CP
Implementation Date: January 3, 2017

Provider Types Affected

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

Provider Action Needed

CR 9726 updates the Place of Service (POS) code set by creating a new code (POS 02) for Telehealth services, effective January 1, 2017. You should ensure that your billing staffs are aware of this new POS code.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards, and their implementation guides, adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims.

As a payer, Medicare must be able to recognize, as valid, any valid code from the POS code set that appears on the HIPAA standard claim transaction. Further, unless prohibited by national policy to the contrary, Medicare not only recognizes such codes, but also adjudicates claims that contain these codes.

At times, Medicaid has had a greater need for code specificity than has Medicare; and many of the new codes, over the past few years, have been developed to meet Medicaid's needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Effective January 1, 2017, CMS is creating a new POS code 02 for use by the physician or practitioner furnishing telehealth services from a distant site. CR 9726 updates the current POS code set by adding this new code (POS 02: Telehealth), with a descriptor of "The location where health services and health related services are provided or received, through telecommunication technology."

Medicare will pay for these services using the Medicare Physician Fee Schedule (MPFS), including the use of the MPFS facility rate for Method II Critical Access Hospitals billing on type of bill 85x. This Telehealth POS code would not apply to originating site facilities billing a facility fee.

Remember that under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Modifiers GT (via interactive audio and video telecommunications systems) and GQ (via an asynchronous telecommunications system) are still required when billing for Medicare Telehealth services. If you bill for Telehealth services with POS code 02, but without the GT or GQ modifier, your MAC will deny the service with the following messages:

- Group Code CO

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

Conversely, if you bill for Telehealth services with modifiers GT or GQ, but without POS code 02, your MAC will deny the service with the following messages:

- Group Code CO
- CARC 5 (The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present)
- RARC M77 (Missing/incomplete/invalid/inappropriate place of service)

Additional Information

The official instruction, CR9726, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3586CP.pdf.

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM9769
Related Change Request (CR) #: CR 9769
Related CR Release Date: November 18, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3661CP
Implementation Date: April 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9769 informs MACs about system changes to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure that your billing staffs are aware of these changes.

Background

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

The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. The codes sets are available on the Washington Publishing Company website at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved during the January 2017 committee meeting shall be posted on these sites on or about February 1, 2017. Your MAC will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation date of CR 9769.

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 CR 9769.

Additional Information

The official instruction, CR 9769, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3661CP.pdf.

Correct Coding – Argus II Retinal Prosthesis System

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Argus II Retinal Prosthesis System" is now available on our (Noridian) website.

View the complete Correct Coding - Argus II Retinal Prosthesis System webpage.

Correct Coding – Eclipse Vaginal Insert System – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding – Eclipse Vaginal Insert System – Revised" has been updated.

Summary of changes: The Eclipse™ Vaginal Insert system (Pelvalon, Inc) will no longer be covered by the DME MAC. Bill to the A/B MAC

View the complete Correct Coding – Eclipse Vaginal Insert System - Revised webpage.

Correct Coding – Otto Bock C-Leg Coding – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding- Otto Bock C-Leg Coding Revised" is now available on our (Noridian) website.

View the complete Correct Coding - Otto Bock C-Leg Coding - Revised webpage.

Correct Coding – Pneumatic Compression Devices and Related Appliances – Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Correct Coding - Pneumatic Compression Devices and Related Appliances - Revised" is now available on our (Noridian) website.

View the complete Correct Coding - Pneumatic Compression Devices and Related Appliances - Revised webpage.

Correct Coding of Cuvitru

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

View the complete Correct Coding of Cuvitru webpage.

DMEPOS CBP – Quarterly Update January 2017 – Revised

MLN Matters® Number: MM9792 Revised
Related Change Request (CR) #: CR 9792
Related CR Release Date: November 25, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3668CP
Implementation Date: January 3, 2017

This article was revised due to a revised CR9792, issued on November 25, 2016. The CR was revised to provide an explanation regarding a few changes that have occurred in the 2017 HCPCS file. These changes are noted in the paragraph just prior to the Additional Information section of this article. The CR release date, transmittal number, and the Web address of the CR are also revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9792 provides the January 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 CR9792 to provide the DMEPOS CBP January 2017 quarterly update.

CR9701 provides specific instructions to your Durable Medical Equipment (DME) MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. Note that quarterly updates are available on the DMEPOS Competitive Bidding Program (CBP) website.

Background

The DMEPOS Competitive Bidding Program 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.

To reflect changes in the 2017 HCPCS file, the HCPCS codes and single payment amounts for B9000, B9000MS and E0628 will be removed from the competitive bidding files, effective January 1, 2017. HCPCS codes B9000, B9000MS and E0628 crosswalk to HCPCS codes B9002, B9002MS and E0627, respectively.

Additional Information

The official instruction, CR9792, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3668CP.pdf.

The DMEPOS CBP site (http://www.dmecompetitivebid.com/palmetto/cbicrd2recompete.nsf/DocsCat/Home) includes information on all rounds of the CBP, including product categories, single payment amounts, and the ZIP codes of areas included in the CBP.

Physicians! Are You Ordering Glucose Monitors and Supplies For Your Patient?

Medicare will consider coverage of a glucose monitor and related supplies when the patient's medical record shows the patient has diabetes and you have determined he/she or a caregiver is sufficiently trained to use the prescribed device appropriately. CMS publication 100-3, Section 40.2

For the glucose monitor only, the following is required prior to delivery:

Glucose Monitor Documentation prior to delivery	Glucose Monitor Prescription prior to delivery
An in person/face to face visit within six months prior to prescribing Documenting the patient was evaluated and/or treated for diabetes mellitus supporting need for the item(s) ordered	**A five element order with the following:** • Patient name • Item ordered • National Provider Identifier (NPI) • Date of the order • Prescribing practitioner signature

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

The detailed written order must contain:

Detailed Written Order Elements (DWO) prior to billing	Items provided on periodic basis, test strips and lancets DWO must include
Beneficiary's name	Item(s) to be dispensed
Prescribing practitioner's name	Frequency of use/testing frequency
Date of the order	Quantity to be dispensed
Detailed description of the item(s)	Number of refills
Prescribing practitioner's signature and signature date	

The DME MAC Glucose Monitors Local Coverage Determination (LCD) L33822 defines the quantity of test strips and lancets that are covered when the basic coverage criteria are met as follows:

Treatment Regimen	Basic Coverage Test Strips and Lancets	Prescribed Testing Frequency
Insulin treated	300 per 3 months	3 times a day
Non-insulin treated	100 per 3 months	Once a day

COVERAGE

Additional criteria must be met, documented in your patient's medical record, and made available to the supplier (or review contractor) upon request when quantities of supplies ordered exceed utilization parameters indicated above. These additional documentation requirements are:

Overutilization Documentation
Physician has seen and evaluated the beneficiary's diabetes within six months of ordering quantities of supplies above the normal utilization and has documented in the medical record the specific reason for the additional supplies
Medical records documenting frequency of actual testing by beneficiary • Specific narrative that documents frequency beneficiary is actually testing; or, • Copy of the beneficiary's testing log (must be provided to physician by beneficiary)

Following this guidance will help your patients and the Medicare program by verifying that there is medical documentation to support the provision of a glucose monitor and supplies and allow your patient to receive the items needed to treat their condition. Your assistance will allow Medicare to pay claims appropriately and ensure that your patient receives the items you have prescribed.

Local Coverage Determinations for Glucose Monitors and Supplies:

- Jurisdiction A - https://med.noridianmedicare.com/web/jadme/policies/lcd/active
- Jurisdiction B - http://www.cgsmedicare.com/jb/coverage/lcdinfo.html
- Jurisdiction C - http://www.cgsmedicare.com/jc/coverage/lcdinfo.html
- Jurisdiction D - https://med.noridianmedicare.com/web/jddme/policies/lcd/active

DOCUMENTATION

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

External Infusion Pumps (HCPCS E0781, E0784) Quarterly Results of Documentation Compliance Review

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

- The E0781 review involved 86 claims, of which 41 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 33%.
- The E0784 review involved 39 claims, of which 23 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 56%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) was not received, is incomplete or missing elements.
- Detailed Written Order (DWO) is dated after the date of service with no dispensing order or a DWO was not received.
- Medical documentation was not received.

For complete details, see External Infusion Pumps (HCPCS E0781, E0784) Quarterly Results of Documentation Compliance Review.

External Infusion Pumps (HCPCS J1817) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) J1817. The quarterly edit effectiveness results from June 2016 through September 2016 are as follows:

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

Top Denial Reasons

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

For complete details, see External Infusion Pumps (HCPCS J1817) Quarterly Results of Service Specific Prepayment Review.

GLUCOSE MONITORS

Blood Glucose Test Strips (HCPCS A4253) Quarterly Results of Documentation Compliance Review

The Jurisdiction D DME MAC Medical Review Department is conducting a Documentation Compliance Review (DCR) of HCPCS code(s) A4253KS and A4253KX. A DCR is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to the Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from June 2016 through August 2016, are as follows:

- The A4253KS review involved 11,671 claims, of which 6,523 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 54%.
- The A4253KX review involved 4,622 claims, of which 3,667 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 56%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Testing logs or documentation indicating frequency of testing were not received.
- Proof of Delivery (POD) was not received.
- An incorrect modifier was billed on the claim.

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

HOSPITAL BEDS

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

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

- The E0250 review involved 154 claims, of which 64 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 52%.

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.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation does not contain a valid date stamp or similar.

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

ICD-10

Local Coverage Determinations and Policy Articles Updated with 2017 ICD-10 Annual Updates – Effective October 1, 2016

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "Local Coverage Determinations and Policy Articles updated with 2017 ICD-10 Annual Updates – Effective October 1, 2016" is now available on our (Noridian) website.

View the complete Local Coverage Determinations and Policy Articles updated with 2017 ICD-10 Annual Updates – Effective October 1, 2016 webpage.

IMMUNOSUPPRESSIVE DRUGS

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

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

- The J7507 review involved 2,318 claims, of which 836 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 31%.
- The J7517 review involved 1,389 claims, of which 504 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 34%.
- The J7518 review involved 1,106 claims, of which 378 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 33%.
- The J7520 review involved 308 claims, of which 109 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 34%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Detailed Written Order was not received.
- Proof of Delivery (POD) was not received, was incomplete or missing elements.
- Refill request was not received.

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

LCD AND POLICY ARTICLE REVISIONS

LCD and Policy Article Revisions Summary for September 1, 2016

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for September 1, 2016" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for September 1, 2016 webpage.

LCD and Policy Article Revisions Summary for October 6, 2016

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for October 6, 2016" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for October 6, 2016 webpage.

LCD and Policy Article Revisions Summary for November 10, 2016

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for November 10, 2016" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for November 10, 2016 webpage.

MOBILITY DEVICES

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

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

- The K0001 review involved 868 claims, of which 519 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 54%.
- The K0003 review involved 236 claims, of which 177 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 64%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- Documentation does not support the beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.
- Documentation does not support the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

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

NEBULIZER DRUGS

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

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

- The J7605 review involved 4,460 claims, of which 1,634 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 35%.
- The J7626 review involved 7,094 claims, of which 3,096 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 42%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is incomplete or missing elements.
- Refill request documentation is incomplete or missing elements.
- Medical documentation was not received.

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

ORTHOTICS AND PROSTHETICS

Appropriate Coding and Billing of Lower Limb Prosthetic Covers and Covering Systems

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received a high volume of submitted claims for lower limb prosthetic covers (L5704-L5707) and protective covering systems (L5962, L5964, and L5966) for the same lower limb prosthesis. The need for both of these is rare, and this article is intended to educate suppliers and providers about the occasions where both of these are considered to be reasonable and necessary.

Lower limb prosthetic covers (L5704-L5707) are complete products and afford shape, protection and waterproofing for normal daily usage of the prosthesis. They offer sufficient protection and weatherproofing for patients who require lower limb prosthetics.

Protective outer surface covering systems (L5962, L5964, and L5966) are specialized covers intended to be worn over an existing prosthesis. They are used by a beneficiary who has special needs for protection against unusually harsh environmental situations where it is necessary to protect the lower limb prosthesis beyond the level of that which is afforded by L5704-L5707. They are not covered for cosmetic or convenience reasons, or for everyday usage in a typical environment. This type of product is separate from the covering that is already reimbursed as part of L5704 – L5707 and is rarely necessary.

Documentation to support medical necessity of a protective outer surface covering system (L5962, L5964, and L5966) must indicate the type of extraordinary activities that would justify the need for extra protection afforded by this highly durable item. Again, this type of extra protection is not routinely necessary.

When billing for the protective outer surface covering systems (L5962, L5964 and L5966), information regarding the type of protective cover provided (i.e., manufacturer name, make, model or type) must be included on claims in order to ensure correct coding.

Suppliers should utilize the Medicare Pricing, Data Analysis and Coding Contractor (PDAC) Web site to ensure accurate coding of DMEPOS claims.

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

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

- The L1960 review involved 162 claims, of which 127 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 76%.
- The L1970 review involved 257 claims, of which 190 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 72%.
- The L4360 review involved 328 claims, of which 328 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support substantial modifications were performed to the prefabricated orthosis.
- Documentation does not support medical necessity of custom fabricated rather than prefabricated orthosis.
- Documentation does not support custom fabricated criteria.

For complete details, see Ankle-Foot Orthosis (HCPCS L1960, L1970, & L4360) 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 April 2016 through July 2016 are as follows:

- The L1832 review involved 161 claims, of which 159 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.
- The L1843 review involved 112 claims, of which 111 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

Top Denial Reasons

- Documentation does not justify the code selected for custom fitted versus off the shelf.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support knee instability.
- Proof of Delivery (POD) is incomplete or missing elements.

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

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

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

- The L1833 review involved 650 claims, of which 589 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 92%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support knee instability.
- Documentation does not support an objective description of joint laxity.
- Documentation does not support knee instability due to a condition specified in the group four diagnosis codes.

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

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

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

- The L4361 review involved 378 claims, of which 270 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 73%.

Top Denial Reasons

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

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

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

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

- The L0631 review involved 121 claims, of which 121 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.
- The L0637 review involved 161 claims, of which 159 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support substantial modifications were performed to the prefabricated orthosis.
- Documentation does not support the orthosis was ordered to treat a covered indication.
- The detailed description of the orthosis does not contain sufficient information to verify it is listed in the product classification list on the Pricing, Data Analysis, and Coding (PDAC) contractor website.

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

ORTHOTICS AND PROSTHETICS

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 April 2016 through July 2016 are as follows:

- The L0648 review involved 275 claims, of which 186 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.
- The L0650 review involved 512 claims, of which 425 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 83%.

Top Denial Reasons

- 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.
- Detailed Written Order (DWO) is incomplete or missing elements.

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

OVERPAYMENTS AND REFUNDS

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

Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment

MLN Matters® Number: MM9848
Related Change Request (CR) #: CR 9848
Related CR Release Date: November 10, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3649CP
Implementation Date: April 3, 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 oxygen services provided to Medicare beneficiaries.

Provider Action Needed

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

Key Points of CR9848

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

Volume Adjustment

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

Portable Add-on

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

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

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

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

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

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

The following are possible claims processing scenarios:

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

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

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

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

Unprocessable claims will be returned with the following messages:

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

Additional Information

The official instruction, CR9848, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3649CP.pdf.

Oxygen (HCPCS E0439, E0434) 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) E0439 and E0434. The quarterly edit effectiveness results from April 2016 through July 2016 are as follows:

- The E0439 review involved 86 claims, of which 46 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 55%.
- The E0434 review involved 93 claims, of which 39 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 37%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- The medical record documentation does not support that alternative treatment measures have been tried or considered and deemed clinically ineffective prior to initiating home oxygen therapy.
- The medical record documentation does not support the treating physician has determined that the beneficiary has a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy.
- Detailed Written Order Prior to Delivery (WOPD) is incomplete or missing elements.

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

Oxygen (HCPCS E1390) Quarterly Results of Documentation Compliance Review

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

- The E1390 review involved 1,634 claims, of which 301 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 21%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.
- Certificate of Medical Necessity (CMN) was not received.
- Proof of Delivery (POD) was not received.

For complete details, see Oxygen (HCPCS E1390) Quarterly Results of Documentation Compliance Review.

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

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

- The E0431 review involved 206 claims, of which 129were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 56%.

Top Denial Reasons

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

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

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

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

- The E1390 review involved 2,347 claims, of which 1,243 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 53%.

Top Denial Reasons

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

- The medical record documentation does not support that alternative treatment measures have been tried or considered and deemed clinically ineffective prior to initiating home oxygen therapy.
- The medical record documentation does not support the treating physician has determined that the beneficiary has a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy.
- The medical record documentation does not support the blood gas study was obtained while the beneficiary was in a chronic stable state.

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

Self-Service Reopenings for Oxygen HCPCS Available Through Noridian Medicare Portal

Suppliers with End User access to the Noridian Medicare Portal are able submit reopenings for certain oxygen claims within the portal. The End User must be approved for the Appeals functionality by their Provider Administrator.

The following reopenings may be made:

- Add, replace or remove diagnosis codes
- Add or replace modifiers RR and MS, remove RA modifier
- Reprocess a claim after the Certificate of Medical Necessity (CMN) is on file

Reopenings are available for claims that meet the following criteria:

- No adjustment has been previously made on claim
- No redetermination has been made on claim
- Claim has not been under review
- Claim is not unprocessable (MA130 remark code)
- Reason for denial is not too complex and documentation is not needed
- Claim is not paid
- Claim was processed within one year
- Claim is finalized
- HCPCS code is one of the following:
  - E0424, E0425
  - E0439, E0440
  - E1353
  - E1390, E1391
  - E1405, E1406
  - E0430, E0431
  - E0433, E0434, E0435
  - E1392
  - K0738
  - E0441, E0442, E0443, E0444

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

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

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

PAP DEVICES

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

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

- The E0601KH review involved 3,347 claims, of which 1,581 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 42%.
- The E0601KJ review involved 1,887 claims, of which 847 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 48%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support criteria two continued coverage beyond the first three months.
- Coverage criteria A was not met.
- Documentation does not contain a valid date stamp or similar.

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

PRESSURE REDUCING SUPPORT SURFACES

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

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

- The E0181 review involved 194 claims, of which 113 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 64%.
- The E0185 review involved 146 claims, of which 66 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 45%.

Top Denial Reasons

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

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

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – January 2017

MLN Matters® Number: MM9843
Related Change Request (CR) #: CR 9843
Related CR Release Date: October 28, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3640CP
Implementation Date: January 3, 2017

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9843 provides the January 2017 quarterly update and instructs MACs to download and implement the January 2017 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the revised October 2016, July 2016, April 2016, and the January 2016 Average Sales Price (ASP) drug pricing files for Medicare Part B drugs. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2017 with dates of service January 1, 2017, through March 31, 2017. MACs will not search and adjust claims previously processed unless brought to their attention. Make sure your billing staffs are aware of these changes.

Background

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

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

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

Additional Information

The official instruction, CR9843, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3640CP.pdf.

Overview of the Skilled Nursing Facility Value-Based Purchasing Program

MLN Matters® Number: SE1621

Provider Types Affected

This article is intended for physicians, clinical staff, and administrators of Skilled Nursing Facilities (SNFs) submitting claims under the SNF Prospective Payment System (PPS) to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries during a SNF stay.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) SNF Value-Based Purchasing (VBP) Program is one of many VBP programs that aims to reward quality and improve health care. Beginning October 1, 2018, SNFs will have an opportunity to receive incentive payments based on performance on the specified quality measure.

Background

The Protecting Access to Medicare Act (PAMA) of 2014, enacted into law on April 1, 2014, authorized the SNF VBP program. PAMA requires CMS to adopt a VBP payment adjustment for SNFs beginning October 1, 2018. By law, the SNF VBP Program is limited to a single readmission measure at a time.

PAMA requires CMS, among other things, to:

- Furnish value-based incentive payments to SNFs for services beginning October 1, 2018.
- Develop a methodology for assessing performance scores.
- Adopt performance standards on a quality measure that include achievement and improvement.
- Rank SNFs based on their performance from low to high. The highest ranked facilities will receive the highest payments, and the lowest ranked 40 percent of facilities will receive payments that are less than what they otherwise would have received without the Program.

CMS will withhold 2 percent of SNF Medicare payments starting October 1, 2018, to fund the incentive payment pool and will then redistribute 50-70 percent of the withheld payments back to SNFs through the SNF VBP Program.

Readmissions Measures

Skilled Nursing Facility 30-Day All Cause Readmission Measure (SNFRM)

In the Fiscal Year (FY) 2016 SNF Prospective Payment System (PPS) final rule, CMS adopted the SNFRM as the first measure for the SNF VBP Program. The measure is defined as the risk-standardized rate of all-cause, unplanned hospital readmissions of Medicare beneficiaries within 30 days of discharge from their prior hospitalization. Hospital readmissions are identified through Medicare hospital claims (not SNF claims) so no readmission data is collected from SNFs and there are no additional reporting requirements for the measure. This measure is endorsed by the National Quality Forum.

Readmissions to a hospital within the 30-day window are counted regardless of whether the beneficiary is readmitted directly from the SNF or after discharge from the SNF as long as the beneficiary was admitted to the SNF within 1 day of discharge from a hospital stay. The measure excludes planned readmissions because they do not indicate poor quality of care. The measure is risk-adjusted based on patient demographics, principal diagnosis from the prior hospitalization, comorbidities, and other health status variables that affect probability of readmission.

Other exclusions include patients who were hospitalized for medical treatment of cancer, do not have Medicare Part A coverage for the full 30-day window, and do not have Part A coverage for the 12 months preceding the prior hospital discharge. Additional exclusions include SNF stays with:

- An intervening post-acute care admission within the 30-day window,
- Patient discharge from the SNF against medical advice,

- Principal diagnosis in prior hospitalization was for rehabilitation, fitting of prosthetics, or adjustment of devices,
- Prior hospitalization for pregnancy, and
- Other reasons documented in the measure's technical specifications.

Skilled Nursing Facility 30-Day Potentially Preventable Readmission (SNFPPR) Measure

On July 29, 2016, CMS adopted the SNFPPR measure for future use in the SNF VBP Program. The SNFPPR measure assesses the risk-standardized rate of unplanned, Potentially Preventable Readmissions (PPRs) for Medicare Fee-For-Service SNF patients within 30 days of discharge from a prior hospitalization.

Potentially preventable hospital readmissions for post-acute care are defined using the existing evidence, empirical analysis, and technical expert panel input. However, the key difference between the SNFRM and SNFPPR measures is that the SNFPPR focuses on potentially preventable readmissions rather than all-cause readmissions. As required by the Program's statute, CMS will replace the SNFRM with the SNFPPR as soon as practicable.

Performance Scoring

CMS has adopted these scoring methodologies to measure SNF performance that includes levels of achievement and improvement:

- Achievement scoring compares a SNF's performance rate in a performance period against all SNFs' performance during the baseline period
- Improvement scoring compares a SNF's performance during the performance period against its own prior performance during the baseline period

For FY 2019 of the SNF VBP Program, achievement scoring will compare SNFs' 2017 performance to the performance of all facilities during Calendar Year (CY) 2015. Improvement scoring methodology will compare a SNFs' 2017 performance to its own performance during CY 2015. For more information about the SNF VBP Program's scoring methodology, refer to the FY 2017 SNF PPS final rule.

Quality Feedback Reports

On October 1, 2016, SNFs will begin receiving quarterly confidential feedback reports about their performance in the SNF VBP Program via the Certification and Survey Provider Enhanced Reporting (CASPER) system.

Additional Information

For more information about the SNF VBP Program, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html and refer to the FY 2016 SNF PPS final rule and the FY 2017 SNF PPS final rule.

If you have additional questions, please email them to: SNFVBPinquiries@cms.hhs.gov.

THERAPEUTIC SHOES

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

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

- The A5500 review involved 2,499 claims, of which 1,869 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 74%.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support the certifying physician has documented in the beneficiary's medical record one of the specified conditions.
- Documentation of the in-person with supplier at the time of delivery is incomplete.
- Documentation does not support the certifying physician has certified that indications one and two 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.

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

UPDATES

Internet-Only Manual, Pub. 100-06, Chapter 3, Section 90 – Provider Liability Revision

MLN Matters® Number: MM9708
Related Change Request (CR) #: CR 9708
Related CR Release Date: November 18, 2017
Effective Date: February 21, 2017
Related CR Transmittal #: R275FM
Implementation Date: February 21, 2017

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9708 provides additional criteria for determining when a contractor shall assume a physician, provider, or supplier should have known about a policy or rule. CR9708 updates Chapter 3, Section 90 of the "Medical Financial Management Manual." Make sure your billing staff is aware of these updates.

Background

Contractors shall assume the provider, physician, or supplier should have known about a policy or rule, if:

- The policy or rule is in the provider, physician, or supplier manual or in Federal regulations;
- The Centers for Medicare & Medicaid Services (CMS) or a CMS contractor provided general notice to the medical community concerning the policy or rule;
- CMS, a CMS contractor, or the Office of Inspector General (OIG) gave written notice of the policy or rule to the particular provider/physician/supplier;

The provider, physician, or supplier was previously investigated or audited as a result of not following the policy or rule;

- The provider, physician, or supplier previously agreed to a Corporate Integrity Agreement as a result of not following the policy or rule;
- The provider, physician, or supplier was previously informed that its claims had been reviewed/denied as a result of the claims not meeting certain Medicare requirements which are related to the policy or rule; or
- The provider, physician, or supplier previously received documented training/outreach from CMS or one of its contractors related to the same policy or rule.

Additional Information

The official instruction, CR9708, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R275FM.pdf. The revised Chapter 3, Section 90, of the manual is attached to CR9708.

IVIG Demonstration: Payment Update for 2017

MLN Matters® Number: MM9746
Related Change Request (CR) #: CR 9746
Related CR Release Date: October 28, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R159DEMO
Implementation Date: January 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Intravenous Immune Globulin (IVIG) drugs and services provided to Medicare beneficiaries under the IVIG demonstration using code Q2502.

Provider Action Needed

Change Request (CR) 9746 specifies the IVIG Demonstration payment rate for services rendered on or after January 1, 2017 through September 30, 2017 for code Q2052 is $354.60. Since the demonstration ends on September 30, 2017, no payment will be made for services rendered after that date. Make sure that your billing staffs are aware of this update.

Background

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

CR 9254 established the payment rate under the demonstration for 2016. CR9746 notifies providers that the payment rate for Q2052: "Services, Supplies and Accessories Used in the Home under the Medicare IVIG Demonstration" for January 1-September 30, 2017 shall be $354.60.

Additional Information

The official instruction, CR9746 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R159DEMO.pdf.

The MLN Matters article related to CR9254 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9254.pdf.

Implement Operating Rules – Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and Claim Adjustment Group Code Rule - Update from CAQH CORE

MLN Matters® Number: MM9767
Related Change Request (CR) #: CR 9767
Related CR Release Date: November 23, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3665CP
Implementation Date: April 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9767 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and 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 HHS (the Secretary) 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.

CR9767 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2017. This update is based on the Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC) updates as posted at the WPC website on or about November 1, 2016. This will also include updates based on Market Based Review (MBR) that CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

See http://www.wpc-edi.com/reference for CARC and RARC updates and http://www.caqh.org/CORECodeCombinations.php for CAQH CORE defined code combination updates.

Note: Per 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/Group Code 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, CR9767, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3665CP.pdf.

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM9774
Related Change Request (CR) #: CR 9774
Related CR Release Date: November 18, 2016
Effective Date: April 1, 2017
Related CR Transmittal #: R3660CP
Implementation Date: April 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9774 updates the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists and instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP and PC Print software if they use that software.

Background

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

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

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

A discrepancy between the dates may arise as the WPC website is only updated three times a year and may not match the CMS release schedule. For this recurring CR, the MACs and the SSMs must get the complete list for both CARC and RARC from the WPC website to obtain the comprehensive lists for both code sets and determine the changes that are included on the code list since the last code update CR (CR 9695).

Additional Information

The official instruction, CR9774, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3660CP.pdf.

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 April 2016 through July 2016 are as follows:

- The A4351 review involved 1,892 claims, of which 1,074 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 50%.
- The A4353 review involved 271 claims, of which 208 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 77%.
- The A4358 review involved 1,381 claims, of which 1,018 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.
- Documentation does not support a permanent urinary incontinence or retention.
- Medical documentation was not received.
- Detailed Written Order (DWO) is incomplete or missing elements.

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

noridian Healthcare Solutions | DME Happenings
900 42nd St. S.
Fargo, ND 58103

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES