DME Happenings

Jurisdiction D
Issue No. 50
March 2016

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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.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 "Noridian E-mail Newsletter Sign Up" at the bottom of the left-hand navigation menu.

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Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

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Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

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

Website: www.noridianmedicare.com/dme	

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

Noridian Email Addresses	
Noridian DME Customer Service	dme@noridian.com
Reopenings and Redeterminations	dmeredeterminations@noridian.com
Noridian 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

CONTACT US

Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com
Jurisdiction B: National Government Services	1-877-299-7900	www.ngsmedicare.com
Jurisdiction C: CGS	1-866-270-4909	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

FYI

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.

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for "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.

New Look and Website Address for Noridian Homepage

Effective January 27, 2016, the Noridian Healthcare Solutions website homepage will have a new look and domain name, https://med.noridianmedicare.com.

For those who have bookmarked the current homepage url, http://www.noridianmedicare.com/, a redirect will be provided.

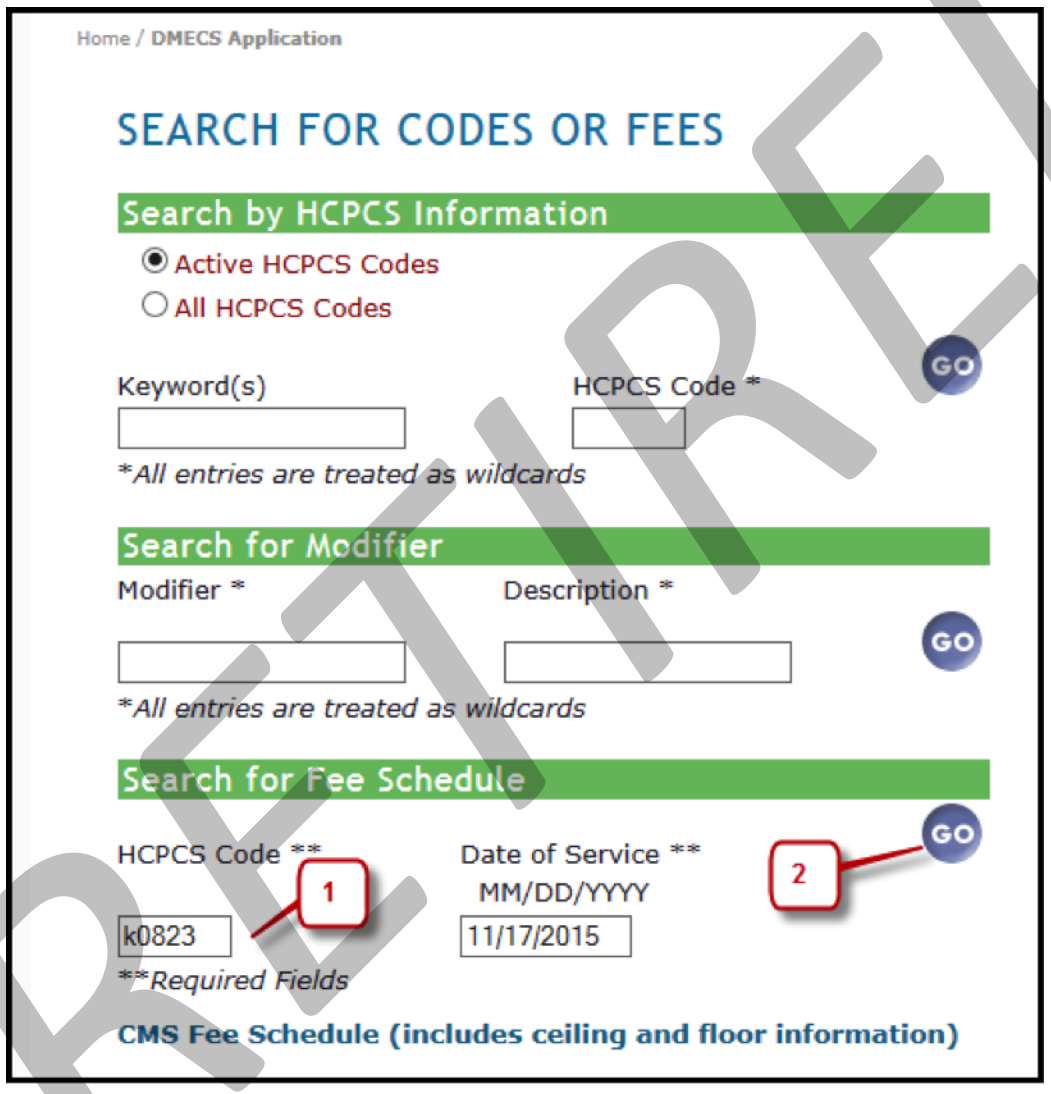
We hope you enjoy the new look coming your way.

DME Fee Schedule Lookup Tool Update

The DME Fee Schedule Lookup Tool has been replaced with the Pricing, Data Analysis and Coding DME Coding System (DMECS) tool. The location of the DMECS inquiry page will remain the same as the previous lookup tool.

DMECS can be searched for HCPCS information, modifiers, fee schedules and product classification lists. To inquire on a fee schedule:

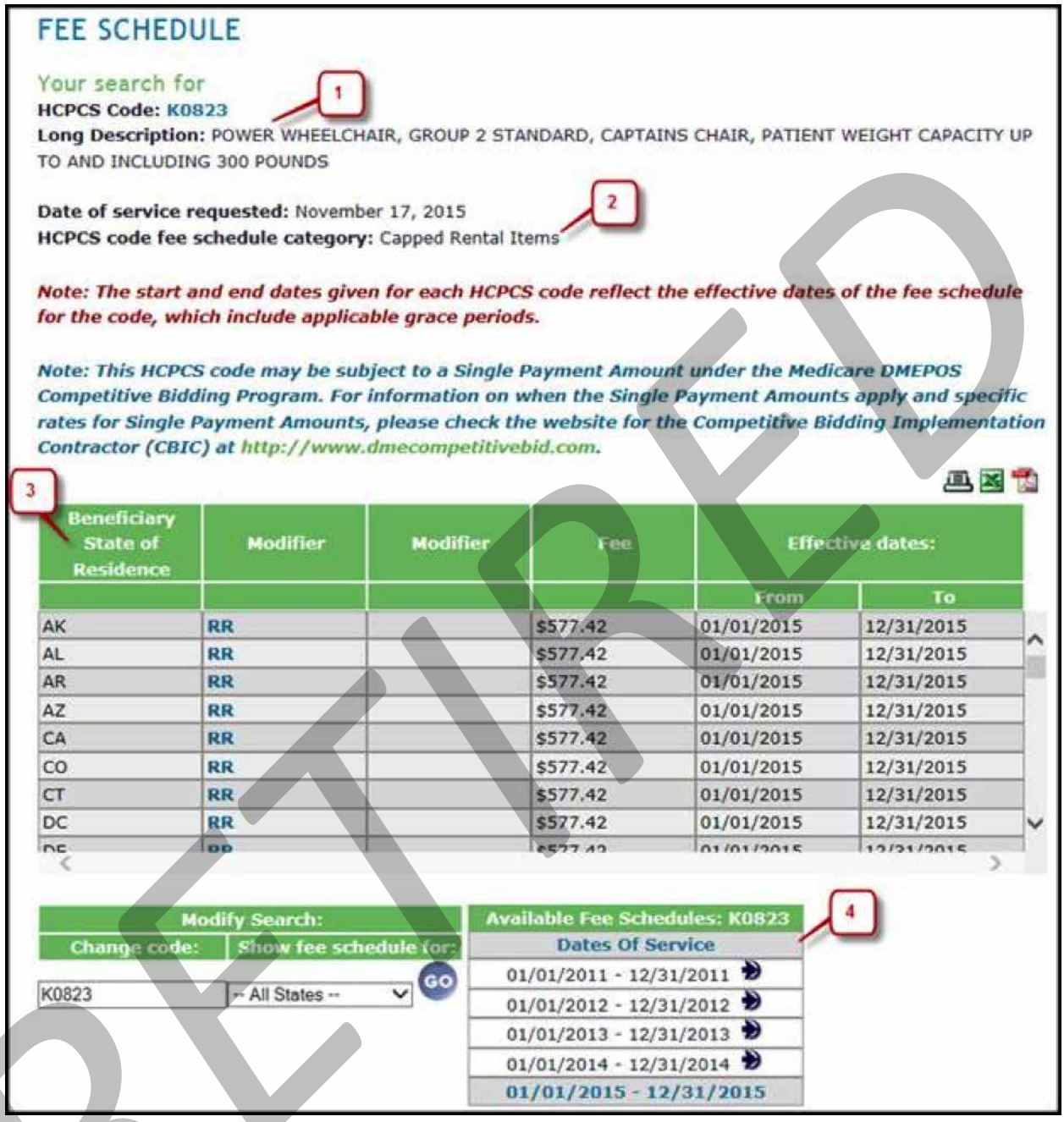
1. Enter the HCPCS code under Search for Fee Schedule.
   - The date of service is auto populated with the current date.
2. Select Go.



The results include:

1. Description of the HCPCS code
2. Fee schedule category
3. Fee schedule amount for each state/modifier

4. Previous year's fee schedules



FEE SCHEDULE

Your search for
HCPCS Code: K0823
Long Description: POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

Date of service requested: November 17, 2015
HCPCS code fee schedule category: Capped Rental Items

Note: The start and end dates given for each HCPCS code reflect the effective dates of the fee schedule for the code, which include applicable grace periods.

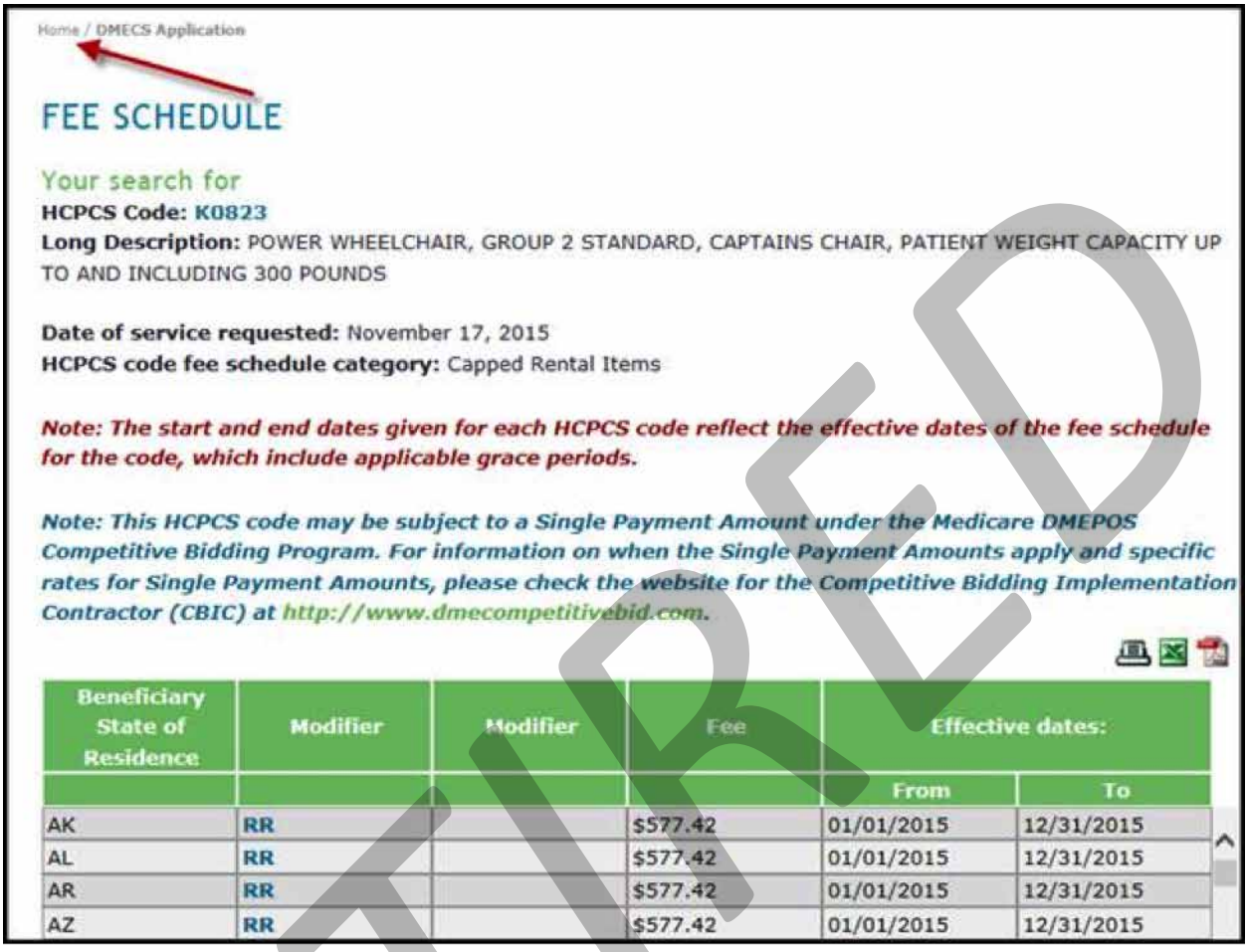
Note: This HCPCS code may be subject to a Single Payment Amount under the Medicare DMEPOS Competitive Bidding Program. For information on when the Single Payment Amounts apply and specific rates for Single Payment Amounts, please check the website for the Competitive Bidding Implementation Contractor (CBIC) at http://www.dmecompetitivebid.com.

Beneficiary State of Residence	Modifier	Modifier	Fee	Effective dates:	
				From	To
AK	RR		$577.42	01/01/2015	12/31/2015
AL	RR		$577.42	01/01/2015	12/31/2015
AR	RR		$577.42	01/01/2015	12/31/2015
AZ	RR		$577.42	01/01/2015	12/31/2015
CA	RR		$577.42	01/01/2015	12/31/2015
CO	RR		$577.42	01/01/2015	12/31/2015
CT	RR		$577.42	01/01/2015	12/31/2015
DC	RR		$577.42	01/01/2015	12/31/2015
DE	RR		$577.42	01/01/2015	12/31/2015

Modify Search:
Change code: K0823 | Show fee schedule for: -- All States -- GO

Available Fee Schedules: K0823
Dates Of Service
01/01/2011 - 12/31/2011
01/01/2012 - 12/31/2012
01/01/2013 - 12/31/2013
01/01/2014 - 12/31/2014
01/01/2015 - 12/31/2015

To return to the inquiry page, select Home.



Beneficiary State of Residence	Modifier	Modifier	Fee	Effective dates:	
				From	To
AK	RR		$577.42	01/01/2015	12/31/2015
AL	RR		$577.42	01/01/2015	12/31/2015
AR	RR		$577.42	01/01/2015	12/31/2015
AZ	RR		$577.42	01/01/2015	12/31/2015

Additional instructions for using this tool are provided on the PDAC DMECS website.

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 1-888-826-5708.
What are the hours for Telephone Reopenings?	Monday through Friday 8 a.m. - 4:30 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.

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-888-826-5708.

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

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-888-826-5708.

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, titled "Denied Claims Requiring CMN/DIF Must be Resubmitted, Rather than Reopened"
	• Oxygen break in service (BIS) issues
	• Some manual wheelchairs and all power mobility devices (PMDs) – HCPCS K0005 and higher
	• Overpayments or reductions in payment
	• Medicare Secondary Payer (MSP) issues
	• Claims denied for timely filing
	• Reopenings past one year from the initial determination
	• Complex Medical Reviews or Additional Documentation Requests
	• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues
	• Repair and labor claims
	• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing
	• The following modifier changes or additions:
	  • A1 through A9
	  • K0 through K4
	  • GA
	  • GY
	  • GZ
	  • KX
	  • EY
	  • KG
	  • RA
	  • RB
	  • RP
	• Certain HCPCS codes (not all-inclusive list)
	  • A4450 through A4452
	  • E0194
	  • E0748
	  • E1028
	  • J1559
	  • J1561
	  • J1562
	  • K0108
	  • K0462

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-888-826-5708.
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.

DME on Demand – Appeals: Redeterminations

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Redetermination
- Who Can Request an Appeal
- Redetermination Examples
- Redetermination Required Documentation
- Redetermination Form
- Submitting Redetermination Requests
- Redetermination Helpful Hints
- Overpayment Redeterminations
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Appeals: Completing the Redeterminations Form

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Interactive Redeterminations Form
- Supplier Information
- Jurisdiction

- Beneficiary Information
- Contact Information for Requestor
- Redetermination Form Requestor's Signature
- Overpayment Appeal
- Claim Information
- Suggested Documentation Checklist
- Reason/Rationale
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Appeals: Levels of Appeals

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Levels of Appeals
- Redeterminations
- Reconsiderations
- Administrative Law Judge (ALJ)
- Medicare Appeals Council
- Federal Court Review
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

Medicare Deductible, Coinsurance and Premium Rates for 2016

MLN Matters® Number: MM9410
Related Change Request (CR) #: CR 9410
Related CR Release Date: November 25, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R96GI
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) provides instruction for MACs to update the claims processing system with the new Calendar Year (CY) 2016 Medicare deductible, coinsurance, and premium rates. Make sure your billing staffs are aware of these changes.

Background

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

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

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

2016 Part A - Hospital Insurance (HI)

- **Deductible:** $1,288.00
- **Coinsurance**
  - $322.00 a day for 61st-90th day
  - $644.00 a day for 91st-150th day (lifetime reserve days)
  - $161.00 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
- **Base Premium (BP):** $411.00 a month

- **BP with 10% surcharge:** $452.10 a month
- **BP with 45% reduction:** $226.00 a month (for those who have 30-39 quarters of coverage)
- **BP with 45% reduction and 10% surcharge:** $248.60 a month

2016 Part B - Supplementary Medical Insurance (SMI)

- **Standard Premium:** $121.80 a month
- **Deductible:** $166.00 a year
- **Pro Rata Data Amount**
  - $118.86 1st month
  - $47.14 2nd month
- **Coinsurance:** 20 percent

Additional Information

The official instruction, CR 9410, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R96GI.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Manual Update to Pub. 100-04, Chapter 20, to Include Used Rental Equipment

MLN Matters® Number: MM9488
Related Change Request (CR) #: CR9488
Related CR Release Date: January 29, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3443CP
Implementation Date: July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9488 notifies providers and suppliers that effective July 1, 2016, when a beneficiary elects to purchase previously rented Inexpensive and Routinely Purchased (IRP) DME, and the service has a UE (purchase of used equipment) modifier, the Medicare allowed amount for used purchased equipment will be calculated at the lower of the purchase fee schedule amount (UE) minus previous paid rental amounts or the actual charge for the used purchased equipment.

This is a new policy for the Centers for Medicare and Medicaid Services (CMS) therefore; the purpose of this CR9488 is to add manual subsection, 30.1.1.2 "Used Rental Equipment" to Chapter 20 of Pub. 100-4, the "Medicare Claims Processing Manual."

Background

The payment rules for capped rental DME and IRP DME are laid out in Section1834 (a) (7) and (2) of the Social Security Act. When determining the Medicare payment amount in instances where the beneficiary elects to purchase previously rented IRP DME, the Medicare allowed amount should take into consideration payment made for any previous rentals when determining the allowed amount for the purchased equipment. Specifically, when a beneficiary elects to purchase used equipment under the IRP payment category after having made previous capped rental monthly payments, the Medicare allowed amount for the used purchased equipment should be capped at the lower of:

- The purchase used (UE) fee schedule amount minus previous rental payments; or
- The actual charge for the used equipment.

Additional Information

The official instruction, CR9488 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3443CP.pdf on the CMS website.

Reminder – Ordering Physician and CMS-1500 Claim Form

Joint DME MAC Publication

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have noted an increase in Comprehensive Error Rate Testing (CERT) program denials when the name and National Provider Identifier (NPI) of the referring provider, listed in Item 17 and Item 17b of the CMS-1500 claim form do not match the name and NPI of the physician who completed the order. Title XVIII §1833(q) of the Social Security Act requires the referring/ordering physician information be submitted on a Medicare claim when the billing provider/supplier has received a referral or order for the referred/ordered service(s) or item.

This type of error can occur as the result of Medicare beneficiaries who are under the care of multiple physicians or the death, reassignment or retirement of their primary care provider, resulting in a change in providers. Suppliers are strongly encouraged to check their documentation from referring physicians or other healthcare practitioners and ensure that the information listed in Item 17 and Item17b on the CMS-1500 form for the referring provider matches the information on the order for any item of durable medical equipment, orthotics, prosthetics or supplies (DMEPOS).

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.

DME on Demand – CERT

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- What is Comprehensive Error Rate Testing (CERT)?
- Contact Information – Livanta
- Responding to a Request for Documentation from CERT
- Decrease CERT Errors
- CERT Inquiries
- Quick Look CERT Documentation Chart
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials & Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

MLN Connects® Provider eNews – December 3, 2015

MLN Connects® Provider eNews for December 03, 2015

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MLN Connects® Events

- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call – Last Chance to Register
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call – Last Chance to Register
- ESRD QIP: Payment Year 2019 Final Rule Call – Register Now

Other CMS Events

- Comparative Billing Report on Physical Therapy Webinar

Announcements

- CMS Updates Quality Strategy
- CMS Awards $110 Million in ESRD Network Funding
- Corrections Being Made to 2016 DMEPOS Fee Schedules
- CMS to Release Comparative Billing Report on Home E/M Services in December
- Hospital IQR and Medicare EHR Incentive Programs: Data Submission Deadline Extended
- PQRS Changes in 2016 Physician Fee Schedule Final Rule
- National Influenza Vaccination Week: December 6 through 12

Claims, Pricers, and Codes

- Extracorporeal Photophoresis and PTA Claims Editing Incorrectly

Medicare Learning Network® Publications

- Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool – New
- ICD-10 Website Wheel Educational Tool – Revised
- Hospital Reclassifications Fact Sheet – Revised
- PECOS for DMEPOS Suppliers Fact Sheet – Revised
- Medicare Disproportionate Share Hospital Fact Sheet – Revised
- DMEPOS Quality Standards Booklet – Revised

MLN Connects® Provider eNews – December 10, 2015

MLN Connects® Provider eNews for December 10, 2015

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In This Edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call — Register Now

MLN Connects Videos

- ICD-10 Post-Implementation: Coding Basics Revisited

Announcements

- CMS Releases 2014 National Health Expenditures
- ICD-10 Specialty Resources Guide

- EHR Incentive Programs: 2015 Program Requirement Resources
- Hospital Compare Website Refresh
- New ST PEPPER Available
- Hospice Item Set Record Submissions: CASPER Reports Available
- Long-Term Care Facilities: Mandatory Electronic Staffing Data Submission Begins in 2016
- 2016 Value Modifier Informal Review Deadline December 16
- 2016 PQRS Payment Adjustment: Informal Review Deadline December 16
- Corrections Made to 2016 DMEPOS Fee Schedules

Medicare Learning Network® Publications

- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course – Revised
- Health Care Professional Frequently Used Web Pages Educational Tool – Revised
- Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet – Revised
- Reading the Institutional Remittance Advice Fact Sheet – Revised

MLN Connects® Provider eNews – December 17, 2015

MLN Connects® Provider eNews for December 17, 2015

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In This Edition:

Editor's Note

Happy holidays from the eNews staff! The next regular edition of the eNews will be released on Thursday, January 7, 2016.

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call – Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session – Registration Now Open
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call – Registration Opening Soon
- New Audio Recording and Transcript Available

Announcements

- CMS Expands Quality Data on Physician Compare and Hospital Compare
- CMS Hospital-Acquired Conditions Reduction Program: FY 2016 Results
- Corrections Made to 2016 DMEPOS Fee Schedules

Claims, Pricers, and Codes

- January 2016 Average Sales Price Files Available
- FY 2016 Inpatient PPS PC Pricer Update Available
- Claims Processing Issue for Reference Laboratory and Anti-markup Payment Limitation Services Resolved

Medicare Learning Network® Videos

- CMS Provider Minute: Hospital Discharge Day Management Services Video – New
- What is the HIPAA Privacy Rule? Tips to Protect Your Patients' Privacy Video – New

Medicare Learning Network Publications

- Reading a Professional Remittance Advice Booklet– Revised
- New MLN Provider Compliance Fast Fact

MLN Connects® Provider eNews – January 7, 2016

MLN Connects® Provider eNews for January 07, 2016

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In This Edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call – Register Now
- Collecting Data on Global Surgery as Required by MACRA Listening Session – Register Now
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call – Register Now
- New Audio Recordings and Transcripts Available
- Stay Informed about Medicare Program Changes

Other CMS Events

Comparative Billing Report on Home E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- FY 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data MLN Matters® Article – Released
- Remittance Advice Resources and FAQs Fact Sheet – New
- Medicare Overpayments Fact Sheet – Revised
- Medicare Vision Services Fact Sheet – Revised
- Screening, Brief Intervention, and Referral to Treatment Services Fact Sheet – Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet – Revised
- Certificate of Medical Necessity Web-Based Training Course – Revised
- New Educational Web Guides Fast Fact

Announcements

- Medicare FFS Utilization and Payment Data Available for HHAs
- CMS Finalizes Rule Creating Prior Authorization Process for Certain DMEPOS Items
- CMS Quality Measure Development Plan
- Improving the Submission of Quality Data to CMS Quality Reporting Programs
- Pilot Project to Test Improving Patients' Health by Addressing Their Social Needs
- EHR Incentive Programs: 2015 Program Year Attestation Begins January 4
- PQRS: Submission Timeframes for 2015 Data
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- IRF Data Submission Deadline Extended to February 15
- LTCH Data Submission Deadline Extended to February 15
- LTCH QRP: FAQs and Provider Training Materials Available
- Hospice Item Set Timeliness Compliance Threshold Fact Sheet Available

- Improving the Documentation of Chiropractic Services Video
- Reporting the Diabetes: Hemoglobin A1c Measure for Program Year 2015
- CMS to Release a Comparative Billing Report on Domiciliary E/M Services in January
- January Quarterly Provider Update Available
- Get Your Patients Off to a Healthy Start in 2016
- Continue Seasonal Influenza Vaccination through January and Beyond

Claims, Pricers, and Codes

- Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 MPFS
- Provider Enrollment Application Fee Amount for CY 2016
- Clarification for Coding Relating to Cologuard
- January 2016 OPPS Pricer File Available
- January 2016 FQHC Pricer Files Available
- Transcatheter Mitral Valve Repair Claims Editing Incorrectly
- Pharmacogenomic Testing for Warfarin Responsiveness Claims Editing Incorrectly
- Adjustments to Correct Home Health Claim Payments

MLN Connects® Provider eNews – January 14, 2016

MLN Connects® Provider eNews for January 14, 2016

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In This Edition:

MLN Connects® Events

- ESRD QIP: Payment Year 2019 Final Rule Call – Last Chance to Register
- Collecting Data on Global Surgery as Required by MACRA Listening Session – Last Chance to Register
- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call – Register Now

Medicare Learning Network® Publications and Multimedia

- Introduction to the IMPACT Act of 2014 Video – New
- Preventive Services Poster – New
- Drug Diversion: Schemes, Auditing, and Referrals Web-Based Training – New
- Medicare Parts C and D General Compliance Training Web-Based Training – New
- Combatting Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training – New
- Medicare Quarterly Provider Compliance Newsletter Educational Tool – New
- Hospice Payment System Fact Sheet – Revised
- ICD-10 Post-Implementation: Coding Basics Revisited Video – Reminder

Announcements

- Accountable Care Organization Initiatives Announced to Improve Health System Care Delivery
- Home Health Compare: Deadline to have Data Suppressed is January 25
- CMS to Release a Comparative Billing Report on Electrodiagnostic Testing in February
- Revised Two-Midnight Rule Guidelines

- PQRS Web-Based Measure Search Tool
- January is Cervical Health Awareness Month

MLN Connects® Provider eNews – January 21, 2016

MLN Connects® Provider eNews for January 21, 2016

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In This Edition:

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call – Register Now

Other CMS Events

- Comparative Billing Report on Domiciliary E/M Services Webinar

Medicare Learning Network® Publications and Multimedia

- PECOS FAQs Fact Sheet – Revised
- The Medicare Home Health Benefit Booklet – Revised

Announcements

- CMS Updates Open Payments Data and Improves Website
- Open Payments System Downtime from January 21 through 26
- LTCH Quality Reporting Program Data Submission Deadline: February 15
- IRF Quality Reporting Program Data Submission Deadline: February 15
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- LTCH and IRF Dry Run Readmission Reports Available
- Update to IRF-PAI Training Manual V1.4
- Read More about What is Next for the EHR Incentive Programs
- Help Protect the Vision of Your Medicare Patients

Claims, Pricers, and Codes

- January 2016 OPPS Pricer File Update

MLN Connects® Provider eNews – January 28, 2016

MLN Connects® Provider eNews for January 28, 2016

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In This Edition:

MLN Connects® Events

- IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call – Last Chance to Register

Other CMS Events

- Special Open Door Forum: Understanding the IMPACT Act
- LTCH Quality Reporting Program Webinar
- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- CMS Provider Minute: Duplicate Professional Claims Video – New
- Medicare Advance Beneficiary Notices Booklet – Revised
- Skilled Nursing Facility Billing Reference Fact Sheet – Revised
- Suite of Products & Resources for Billers & Coders Educational Tool – Revised
- Suite of Products & Resources for Compliance Officers Educational Tool – Revised
- Suite of Products & Resources for Educators & Students Educational Tool – Revised
- Suite of Products & Resources for Inpatient Hospitals Educational Tool – Revised
- Updated MLN Matters® Search Indices
- New Educational Web Guides Fast Fact

Announcements

- CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries
- PQRS: Submission Timeframes for 2015 Data
- Comment Period for IMPACT Act Measures Extended to January 29
- PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31
- CMS to Release a Comparative Billing Report on Modifier 25: Internal Medicine in February
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Prior Authorization for Certain DMEPOS Items: FAQs on the Final Rule
- PEPPERs Available for SNFs, HHAs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
- Payment for Group 3 Power Wheelchair Cushions and Accessories
- Changes to the Medicare EHR Incentive Program Hardship Exception Process
- Testing QRDA I Release 2 and QRDA III Release 1 Files

Claims, Pricers, and Codes

- New Drug Testing Laboratory Codes Editing Incorrectly

MLN Connects® Provider eNews – February 4, 2016

MLN Connects® Provider eNews for February 4, 2016

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In This Edition:

MLN Connects® Events

- New Audio Recordings and Transcripts Available

Other CMS Events

- Medicare Quality Reporting Programs Webinar: What Eligible Providers Need to Know in 2016

Medicare Learning Network® Publications and Multimedia

- Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters® Article – Revised
- Implementation of Fingerprint-Based Background Checks MLN Matters Article – Revised
- The Medicare Home Health Benefit Web-Based Training Course – Revised
- Remittance Advice Information: An Overview Fact Sheet – Revised

- Medicare Advance Beneficiary Notices Booklet – Revised
- How to Use the Searchable Medicare Physician Fee Schedule Booklet – Revised

Announcements

- CMS Announces Proposed Improvements to Medicare Shared Savings Program
- CMS Releases Home Health Patient Experience of Care Star Ratings
- New Proposal to Give Providers and Employers Access to Information to Drive Quality and Patient Care Improvement
- Comment Period for IMPACT Act Measures Extended to February 5
- Comment Period for RFI on Reporting of Quality Measures Extended to February 16
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- Register in Open Payments System to Review and Dispute 2015 Data
- 2015 PQRS Data: Submission Deadlines
- Applying for an EHR Hardship Exception: FAQs
- Temporary Moratoria Extended on Enrollment of New Home Health Agencies and Part B Ambulance Suppliers
- Stop Hepatitis C Virus Transmission in Patients Undergoing Hemodialysis
- Flu Season Begins: Severe Influenza Illness Reported
- February is American Heart Month

MLN Connects® Provider eNews – February 11, 2016

MLN Connects® Provider eNews for February 11, 2016

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In This Edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call – Registration Now Open

Other CMS Events

- Physician Compare Public Reporting Information Sessions

Medicare Learning Network® Publications and Multimedia

- Telehealth Services Fact Sheet – Revised
- Ambulance Fee Schedule Fact Sheet – Revised
- Reading a Professional Remittance Advice Booklet – Reminder

Announcements

- 39 Million Medicare Beneficiaries Utilized Free Preventive Services in 2015
- Nursing Facility Initiative Annual Report
- EHR Incentive Programs: Clinical Decision Support Interventions
- EHR Incentive Programs: New Tipsheet on Eligibility for Broadband Access Exclusions
- Implementation of Section 2 of the Patient Access and Medicare Protection Act
- Influenza Activity Continues

Claims, Pricers, and Codes

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

MLN Connects® Provider eNews – February 18, 2016

MLN Connects® Provider eNews for February 18, 2016

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In This Edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call – Register Now
- New Audio Recording and Transcript Available

Other CMS Events

- Comparative Billing Report on Electrodiagnostic Testing Webinar

Medicare Learning Network® Publications and Multimedia

- Medicare Basics Commonly Used Acronyms Educational Tool – Revised
- PECOS Technical Assistance Contact Information Fact Sheet – Reminder
- Medicare Enrollment for Physicians and Other Part B Suppliers Fact Sheet – Reminder

Announcements

- Medicare Reporting and Returning of Self-Identified Overpayments
- IMPACT Act Technical Expert Panel Call for Nominations through February 26
- Submitting Comments on MACRA Episode Groups: Deadline Extended to March 1
- 2015 PQRS EHR Submission Deadline Extended to March 11
- EHR Incentive Programs Attestation Deadline Extended to March 11
- Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
- EHR Incentive Programs: Updated FAQs Available

MLN Connects® Provider eNews – February 25, 2016

MLN Connects® Provider eNews for February 25, 2016

View this edition as a PDF

In This Edition:

MLN Connects® Events

- Provider Enrollment Revalidation Call – Last Chance to Register
- Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology – New

Medicare Learning Network® Publications and Multimedia

- Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs, FQHCs, and CAHs MLN Matters® Article – Released
- Ambulatory Surgical Center Fee Schedule Fact Sheet – Revised
- New Educational Web Guides Fast Fact

CMS ENEWS

Announcements

- Alignment and Simplification of Quality Measures
- CMS Publishes Medicare FFS Provider and Supplier Lists
- Strengthening Provider and Supplier Enrollment Screening
- CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1
- Quality of Patient Care Star Ratings TEP: Nomination Period Open through March 18
- EHR Hardship Exception Application: New FAQ

CODING

DMEPOS HCPCS Code Jurisdiction List - 2016

MLN Matters® Number: MM9481
Related Change Request (CR) #: CR9481
Related CR Release Date: December 31, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3432CP
Implementation Date: February 1, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9481 notifies suppliers that the spreadsheet containing an updated jurisdiction list of Healthcare Common Procedure Coding System (HCPCS) codes is updated annually to reflect codes that have been added or discontinued (deleted) each year. Changes in Chapter 23, Section 20.3 of the "Medicare Claims Processing Manual" are reflected in the recurring update notification. The spreadsheet for the 2016 DMEPOS Jurisdiction List is an Excel® spreadsheet and is available under the Coding Category at http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html and is also attached to CR9481.

Additional Information

The official instruction, CR9481, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3432CP.pdf on the CMS website.

POS Codes for Outpatient Hospitals – New and Revised – Revised

MLN Matters® Number: MM9231 Revised
Related Change Request (CR) #: CR 9231
Related CR Release Date: August 6, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3315CP
Implementation Date: January 4, 2016

This article was revised on December 9, 2015, to clarify the effective date of POS 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim, regardless of the date of service, when it is processed on or after January 1, 2016. The title of the table on page 2 was also changed for clarification. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9231, from which this article is taken, updates the "Medicare Claims Processing Manual" by:

- Revising the current Place of Service (POS) code set by adding new POS code 19 for "Off Campus-Outpatient Hospital" and revising POS code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital;" and
- Making minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility).

You should ensure that your billing staffs are aware of these POS code changes.

Background

As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with HIPAA's standards and their implementation guides. The currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains.

The POS code set provides care-setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for code specificity than Medicare, and many of the past years' new codes that 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 that they require. Therefore, as a payer, Medicare must be able to recognize any valid code from the POS code set that appears on the HIPAA standard claim transaction.

Therefore, in response to the discussion in the CY 2015 Physician Fee Schedule (PFS) final rule with comment period published on November 13, 2014 (79 FR 67572); in order to differentiate between on-campus and off-campus provider-based hospital departments, CMS is creating a new POS code (POS 19) and revising the current POS code description for outpatient hospital (POS 22).

CR 9231, from which this article is taken, provides this POS code update, effective January 1, 2016. Specifically, CR 9231updates the current POS code set by adding new POS code 19 for "Off Campus-Outpatient Hospital" and revising POS code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital" as described in the following table.

New and Revised POS Codes for Claims Processed on or after January 1, 2016 (Regardless of Service Date)

Code	Descriptor
POS 19 Off Campus-Outpatient Hospital	Descriptor: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
POS 22 On Campus-Outpatient Hospital	Descriptor: A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

CR9231 also:

- Implements the systems and local contractor level changes needed for Medicare to adjudicate claims with the new and revised codes (your B MAC or DME MAC will develop policies as needed to edit and adjudicate claims that contain these new/revised codes according to Medicare national policy); and
- Makes minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility) by adding those two codes back into the POS list in the "Medicare Claims Processing Manual." Those two codes were removed inadvertently from a prior version of that manual.

Additional Information Related to POS Codes 19 and 22

- Payments for services provided to outpatients who are later admitted as inpatients within 3 days (or, in the case of non-IPPS hospitals, 1 day) are bundled when the patient is seen in a wholly owned or wholly operated physician practice. The 3-day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. The 3-day payment rule will also apply to services billed with POS code 19.
- Claims for covered services rendered in an Off Campus-Outpatient Hospital setting (or in an On Campus-Outpatient Hospital setting, if payable by Medicare) will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply to this POS, and will now also apply to POS 19 unless otherwise stated.
- Reporting outpatient hospital POS code 19 or 22 is a minimum requirement to trigger the facility payment amount under the PFS when services are provided to a registered outpatient. Therefore, you should use POS code 19 or POS code 22 when you furnish services to a hospital outpatient regardless of where the face-to-face encounter occurs.
- Your MACs will allow POS 19 to be billed for G0447 (Face-to-face behavioral counseling for obesity, 15 minutes) and G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes) in the same way as those services are billed with POS code 22.

Additional Information

The official instruction, CR9231, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf on the CMS website.

New Non-Physician Specialty Code for Dentist

MLN Matters® Number: MM9355
Related Change Request (CR) #: CR 9355
Related CR Release Date: January 29, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3447CP and R262FM
Implementation Date: July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9355 announces that the Centers for Medicare & Medicaid Services (CMS) has created a new non-physician specialty code (C5) for Dentist.

Background

Physicians self-designate their Medicare physician specialty on the Medicare enrollment application ((CMS-855B, CMS-855I or CMS-855O) or Internet-based Provider Enrollment, Chain and Ownership System (PECOS) when they enroll in the Medicare program. Non-physician practitioners are assigned a Medicare specialty code when they enroll.

The specialty code becomes associated with the claims that the physician or non-physician practitioner submits, and describes the specific/unique types of medicine that they (and certain other suppliers) practice. CMS uses specialty codes for programmatic and claims processing purposes.

Additional Information

The official instruction, CR9355, issued to your MAC regarding this change consists of two transmittals. The first revises the "Medicare Claims Processing Manual" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3447CP.pdf on the CMS website.
The second transmittal updates the "Medicare Financial Management Manual" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R262FM.pdf on the CMS website.

HPTCs Code Set Update – April 2016

MLN Matters® Number: MM9461
Related Change Request (CR) #: CR 9461
Related CR Release Date: February 19, 2016
Effective Date: April 1, 2016
Implementation Date: As soon as April 1, 2016, but no later than July 5, 2016
Related CR Transmittal #: R3467CP

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9461 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference files.

Background

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

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

You should note that:

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

CR9461 implements the NUCC HPTC code set that is effective on April 1, 2016, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

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

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

Additional Information

The official instruction, CR9461, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3467CP.pdf on the CMS website.

Correct Coding – 2016 HCPCS Code Annual Update

DME MAC Joint Publication

The following tables identify changes to Level II Healthcare Common Procedure Coding System (HCPCS) codes for 2016. The tables contain only the 2016 HCPCS codes that are applicable to items that fall within Medicare DME MAC jurisdiction. There may be other HCPCS code changes for items under the jurisdiction of other Medicare contractors. Consult with those contractors for information regarding HCPCS codes that fall within their areas of responsibility.

All HCPCS code changes are effective for claims with dates of service on or after January 1, 2016.

Code Change Categories

Added Codes/Added Modifiers: These are new codes and modifiers.

Discontinued Codes/Deleted Modifiers: These are codes and modifiers that are discontinued /deleted. These codes and modifiers continue to be valid for Medicare claims with dates of service on or before December 31, 2015.

If there is a direct crosswalk for a discontinued/deleted code or modifier, the crosswalk code is listed in the table. The crosswalked codes are effective for claims with dates of service on or after January 1, 2016.

There is no grace period that allows for submission of a discontinued code/modifier for claims with dates of service in 2016.

Narrative Changes/Revised Modifiers: These are changes in the narrative descriptor for an existing code or modifier.

For products not listed on the DMECS Product Classification Lists, suppliers should evaluate whether a revised narrative changes their coding choices.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com/

Code Tables

The appearance of a code in the tables below does not necessarily indicate coverage. Refer to the applicable Local Coverage Determination for information regarding Medicare reimbursement requirements.

Ankle-Foot/Knee-Ankle-Foot Orthosis

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
L1902	ANKLE FOOT ORTHOSIS, ANKLE GAUNTLET, PREFABRICATED, OFF-THE-SHELF	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILIAR, WITH OR WITHOUT JOINTS, PREFABRICATED, OFF-THE-SHELF
L1904	ANKLE ORTHOSIS, ANKLE GAUNTLET, CUSTOM-FABRICATED	ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILIAR, WITH OR WITHOUT JOINTS, CUSTOM FABRICATED

Bowel Management

Added Code	
Code	**Narrative**
A4337	INCONTINENCE SUPPLY, RECTAL INSERT, ANY TYPE, EACH

External Infusion Pumps

Added Code	
Code	**Narrative**
J7340	CARBIDOPA 5 MG/LEVODOPA 20 MG ENTERAL SUSPENSION
J9039	INJECTION, BLINATUMOMAB, 1 MICROGRAM
J1575	INJECTION, IMMUNE GLOBULIN/HYALURONIDASE, (HYQVIA), 100 MG IMMUNEGLOBULIN

Immunosuppressive Drugs

Added Code	
Code	**Narrative**
J7503	TACROLIMUS, EXTENDED RELEASE, (ENVARSUS XR), ORAL, 0.25 MG
J7512	PREDNISONE, IMMEDIATE RELEASE OR DELAYED RELEASE, ORAL, 1 MG

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
J7508	TACROLIMUS, EXTENDED RELEASE, ORAL, 0.1 MG	TACROLIMUS, EXTENDED RELEASE, (ASTAGRAF XL), ORAL, 0.1 MG

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
J7506	PREDNISONE, ORAL, PER 5 MG	J7512

Miscellaneous

Added Code	
Code	**Narrative**
J7999	COMPOUNDED DRUG, NOT OTHERWISE CLASSIFIED

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
Q9977	COMPOUNDED DRUG, NOT OTHERWISE CLASSIFIED	J7999

Nebulizers

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
A7011	CORRUGATED TUBING, NON-DISPOSABLE, USED WITH LARGE VOLUME NEBULIZER, 10 FEET	NONE

Oral Antiemetic Drugs

Added Code	
Code	**Narrative**
J8655	NETUPITANT 300 MG AND PALONOSETRON 0.5 MG

Discontinued Code		
Code	**Narrative**	**Crosswalk to Code**
Q9978	NETUPITANT 300 MG AND PALONOSETRON 0.5 MG	J8655

Parenteral Nutrition

Narrative Changes

Code	Old Narrative	New Narrative
B5000	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, RENAL - AMIROSYN RF, NEPHRAMINE, RENAMINE - PREMIX	PARENTERAL NUTRITION SOLUTION COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, RENAL-AMINOSYN-RF, NEPHRAMINE, RENAMINE-PREMIX
B5100	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, HEPATIC - FREAMINE HBC, HEPATAMINE - PREMIX	PARENTERAL NUTRITION SOLUTION COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, HEPATIC, HEPATAMINE-PREMIX
B5200	PARENTERAL NUTRITION SOLUTION: COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, STRESS - BRANCH CHAIN AMINO ACIDS - PREMIX	PARENTERAL NUTRITION SOLUTION COMPOUNDED AMINO ACID AND CARBOHYDRATES WITH ELECTROLYTES, TRACE ELEMENTS, AND VITAMINS, INCLUDING PREPARATION, ANY STRENGTH, STRESS-BRANCH CHAIN AMINO ACIDS-FREAMINE-HBC-PREMIX

Ventilators

Added Code

Code	Narrative
E0465	HOME VENTILATOR, ANY TYPE, USED WITH INVASIVE INTERFACE, (E.G., TRACHEOSTOMY TUBE)
E0466	HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE, (E.G., MASK, CHEST SHELL)

Discontinued Code

Code	Narrative	Crosswalk to Code
E0450	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)	E0465
E0460	NEGATIVE PRESSURE VENTILATOR; PORTABLE OR STATIONARY	E0466
E0461	VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G., MASK)	E0466

Discontinued Code		
E0463	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)	E0465
E0464	PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G., MASK)	E0466

Wheelchair Options/Accessories

Added Code	
Code	**Narrative**
E1012	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, CENTER MOUNT POWER ELEVATING LEG REST/PLATFORM, COMPLETE SYSTEM, ANY TYPE, EACH

Narrative Changes		
Code	**Old Narrative**	**New Narrative**
K0017	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, EACH	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, BASE, REPLACEMENT ONLY, EACH
K0018	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, EACH	DETACHABLE, ADJUSTABLE HEIGHT ARMREST, UPPER PORTION, REPLACEMENT ONLY, EACH

Correct Coding – Face Down Positioning Devices

Joint DME MAC Publication

This article was originally published in 2003 and is being republished as a reminder to suppliers on the correct coding and coverage of these devices.

Following vitrectomy and certain other eye surgery procedures, patients are instructed to position themselves with their face down through most of the day. There are certain devices that facilitate this positioning. Examples (not all-inclusive) are a face cushion that is attached to a frame that can rest on a table or be positioned on a bed, or a cushion pad that is attached to a chair-like device.

CMS has confirmed that these devices are statutorily noncovered because they do not fall within a Medicare benefit category. These types of devices are considered "precautionary devices" and also can be used for purposes other than the treatment of an illness or injury. The denial is a coverage denial, not a medical necessity denial.

For dates of service prior to January 1, 2004, the face cushion and frame should be coded A9270 (NONCOVERED ITEM OR SERVICE). For dates of service on or after January 1, 2004, code E0190 (POSITIONING CUSHION/PILLOW/WEDGE, ANY SHAPE OR SIZE) must be used. For all dates of service, the chair-like device should be coded as A9270.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website.

Correct Coding – inFlow™ Intraurethral Valve-Pump (Vesiflo, Inc.)

DME MAC Joint Publication

The inFlow™ Intraurethral Valve-Pump is a urinary device for women with incomplete bladder emptying due to impaired detrusor contractility (IDC). The inFlowTM is promoted as an alternative to urinary catheters. The device consists of a small catheter with an internal, magnetically-activated pump-valve mechanism. The inFlow™ is placed in the female urethra for up to 30 days. Upon activation by a battery-powered wand held low over the pubic area, the valve opens and the pump induces urine flow.

Effective January 1, 2016, the inFlow™ Intraurethral Valve-Pump was assigned HCPCS code A4335 (INCONTINENCE SUPPLY, MISCELLANEOUS). This HCPCS code must be used on claims for initial issue of inFlow TM, and is all-inclusive (catheter, wand, and batteries). In addition, claims for replacement catheters, batteries, or wands must also use HCPCS code A4335.

Claims must include the manufacturer and product name in the narrative field of the electronic claim.

Refer to the Urological Supplies Local Coverage Determination and related Policy Article for additional information on coverage, coding and documentation.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

Correct Coding and Coverage of Ventilators – Revised Effective January 1, 2016

Joint DME MAC Publication

Originally Posted April 03, 2014

This article has been revised to reflect changes to the 2016 HCPCS codes used for billing Medicare for ventilators. These code changes are effective for claims with dates of service (DOS) on or after January 1 2016.

Ventilator technology has evolved to the point where it is possible to have a single device capable of operating in numerous modes, from basic continuous positive pressure (CPAP and bi-level PAP) to traditional pressure and volume ventilator modes. This creates the possibility that one piece of equipment may be able to replace numerous and different pieces of equipment. Equipment with multifunction capability creates the possibility of errors in claims submitted for these items. This article will discuss the application of Medicare proper coding and payment rules for ventilators.

HCPCS Coding

Effective for claims with dates of service on or after January 1, 2016, the following HCPCS codes have been deleted from the HCPCS Code set:

E0450 - VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G., TRACHEOSTOMY TUBE)

E0460 - NEGATIVE PRESSURE VENTILATOR; PORTABLE OR STATIONARY

E0461 - VOLUME CONTROL VENTILATOR, WITHOUT PRESSURE SUPPORT MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)

E0463 - PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH INVASIVE INTERFACE (E.G. TRACHEOSTOMY TUBE)

E0464 - PRESSURE SUPPORT VENTILATOR WITH VOLUME CONTROL MODE, MAY INCLUDE PRESSURE CONTROL MODE, USED WITH NON-INVASIVE INTERFACE (E.G. MASK)

Claims for DOS on or after the effective date using these codes will be denied as "invalid code".

Effective for claims with DOS on or after January 1, 2016, all products classified as ventilators must be billed using one of the following HCPCS codes:

E0465 - Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)

E0466 - Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)

Products previously assigned to HCPCS codes E0450 and E0463 must use HCPCS code E0465.
Products previously assigned to HCPCS codes E0460, E0461 and E0464 must use HCPCS code E0466.

The PDAC will update the product classification listing in a future update.

Note: Ventilators must not be billed using codes for CPAP (E0601) or bi-level PAP (E0470, E0471, E0472). Using the CPAP or bi-level PAP HCPCS codes to bill a ventilator is incorrect coding, even if the ventilator is only being used in CPAP or bi-level mode (see below). Claims for ventilators used in CPAP or bi-level PAP scenarios will be denied as incorrect coding.

Coverage

Items may only be covered based upon the applicable reasonable and necessary (R&N) criteria applicable to the classification assigned to the device. The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination Manual (Internet-Only Manual, Publication 100-03) in Chapter 1, Part 4, Section 280.1 stipulates that ventilators are covered for the following conditions:

- [N]euromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

Each of these disease categories are comprised of conditions that can vary from severe and life-threatening to less serious forms. These disease groups may appear to overlap conditions described in the Respiratory Assist Devices LCD but they are not overlapping. Choice of an appropriate device i.e., a ventilator vs. a bi-level PAP device is made based upon the severity of the condition. CMS distinguished the use of respiratory product types in a National Coverage Analysis Decision Memo (CAG-00052N) in June 2001:

- RADs [bi-level PAP devices] provide noninvasive positive pressure respiratory assistance (NPPRA). Note that some studies in the literature refer to this as noninvasive positive pressure ventilation (NPPV).
- NPPRA is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access. It may sometimes be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is distinguished from the invasive ventilation administered via a securely intubated airway, in a patient for whom interruption or failure of respiratory support leads to death.

The conditions described in the Respiratory Assistance Devices (RAD) Local Coverage Determination are not life- threatening conditions where interruption of respiratory support would quickly lead to serious harm or death. The RAD policy describes clinical conditions that require intermittent and relatively short durations of respiratory support. Thus, a ventilator would not be eligible for reimbursement for any of the conditions described in the RAD LCD even though the ventilator equipment may have the capability of operating in a bi-level PAP (E0470, E0471, E0472) mode. Bi-level PAP devices (E0470, E0471) are considered as R&N in those clinical scenarios.

A ventilator would not be considered reasonable and necessary (R&N) for the treatment of obstructive sleep apnea, as described in the PAP LCD, even though the ventilator equipment may have the capability of operating in a CPAP (E0601) or bi-level PAP (E0470) mode.

Claims for ventilators used for the treatment of conditions described in the PAP or RAD LCDs will be denied as not reasonable and necessary.

Upgrades

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. In some cases, CMS policy that allows for billing of upgrade modifiers can be used when providing an item or service that is considered beyond what is medically necessary. This is NOT applicable to ventilators in the situations described above.

Although the use of a ventilator to treat any of the conditions contained in the PAP or RAD LCDs is considered "more than is medically necessary", the upgrade billing provisions may not be used to provide a ventilator for conditions described in the PAP or RAD LCDs. CPAP and bi-level PAP items are in the Capped-Rental payment category while ventilators are in the Frequent and Substantial Servicing payment category. Upgrade billing across different payment categories is not possible.

Pricing Category

Ventilators are classified in the Frequent and Substantial Servicing (FSS) payment category. FSS item are those for which there must be frequent and substantial servicing in order to avoid risk to the patient's health. CMS designates the items which fall into this payment group. The monthly rental payment for items in this pricing category is all- inclusive meaning there is no separate payment by Medicare for any options, accessories or supplies used with a ventilator. In addition, all necessary maintenance, servicing, repairs and replacement are also included in the monthly rental. Claims for these items and/or services will be denied as unbundling.

Coverage of Second Ventilator

Medicare does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary - same/similar equipment.

Backup equipment must be distinguished from multiple medically necessary items which are defined as, identical or similar devices each of which meets a different medical need for the beneficiary. Although Medicare does not pay separately for backup equipment, Medicare will make a separate payment for a second piece of equipment if it is required to serve a different purpose that is determined by the beneficiary's medical needs.

The following are examples of situations in which a beneficiary would qualify for both a primary ventilator and a secondary ventilator:

- A beneficiary requires one type of ventilator (e.g. a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g. positive pressure ventilator with a nasal mask) during the rest of the day.
- A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without two pieces of equipment, the beneficiary may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

Refer to the PAP and RAD LCDs and related Policy Articles and to the DME MAC Supplier Manuals for additional information on coverage, coding and documentation of these items.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com/.

Reclassification of Certain DME HCPCS Codes Included in CBP from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category

MLN Matters® Number: MM8822

Related Change Request (CR) #: CR 8822

Effective Date: : July 1, 2016 - except in Round 1 Re- compete CBP areas where effective date is January 1, 2017

Related CR Release Date: February 19, 2016

Implementation Date: July 5, 2016 - except for A/B and HHH MACs where implementation is 10/3/2016

Related CR Transmittal #: R1626OTN

Provider Types Affected

This MLN Matters® Article is intended for suppliers and Home Health Agencies (HHAs) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Home Health & Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided to Medicare beneficiaries.

What You Need to Know

Change request (CR) 8822 provides instructions for the upcoming reclassification of certain Durable Medical Equipment (DME) Healthcare Common Procedure Coding System (HCPCS) codes,that are included in Round 2 and Round 1 Re-compete DMEPOS Competitive Bidding Programs (CBPs), from the inexpensive and routinely purchased DME payment category to the capped rental DME payment category.

CR 8822 follows CR 8566, Rescind and Replace of CR 8409: Reclassification of Certain Durable Medical Equipment from the Inexpensive and Routinely Purchased Payment Category to the Capped Rental Payment Category, which was released on March 25, 2014. You can find the associated MLN Matters® article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8566.pdf on the CMS website. Make sure your billing staffs are aware of these changes.

Background

Medicare defines routinely purchased DME (set forth at 42 CFR §414.220(a)(2)) as equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989 (that is, new codes added to the HCPCS after 1989 for items costing more than $150) showed inconsistencies in applying the definition.

As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. Also in that rule, the Centers for Medicare & Medicaid Services (CMS) established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864), will be paid under the associated lump sum purchase option set forth at 42 CFR § 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the Social Security Act. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

In order to align the payment category with the required regulatory definition, the HCPCS codes in the table below will reclassify to the capped rental payment category effective:

- July 1, 2016: Items furnished in all areas except the nine Round 1 Re-compete CBAs; and
- January 1, 2017: Items furnished in the nine Round 1 Re-compete CBAs.

HCPCS Codes for Items Reclassified to Capped Rental DME Category

HCPCS Code	Description
E0197	Support Surfaces
E0140, E0149	Walkers
E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070	Wheelchairs Options/Accessories
E0955	Wheelchair Seating

Further Details from CR8822:

1. In Round 1 Re-compete CBAs, payment for HCPCS codes shown in the above table will be made under the inexpensive and routinely purchased (IN) payment category for dates of service July 1, 2016 through December 31, 2016. Your MAC will recognize that the capped payment category requires payment of 10 percent of the purchase price for the first three months and 7.5 percent for each of the remaining rental months 4 through 13. You should also be aware that payment amounts will be based on the lower of the supplier's actual charge and the fee schedule amount. Your MAC will return as unprocessable claims for the inexpensive and routinely purchased codes described above that are billed with the KH, KI and KJ modifiers. Such unprocessable claims will be returned with 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 Remark Code (RARC) N519 (Invalid combination of HCPCS modifiers) and Group Code CO (Contractual Obligation).

2. Effective for claims with dates of service on or after July 1, 2016, for items furnished in Round 2 CBAs, your MAC will cease any IN category rental payments for the codes in the above table and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (July 1, 2016)).
3. Effective for claims with dates of service on or after January 1, 2017, for items furnished in Round 1 Re-compete CBAs, your MAC will cease any IN rental payments for these codes, and start payment under the Capped Rental (CR) payment category; applying a determination of the number of rental months paid (which cannot exceed 13 rental months combined from dates of service before and after the effective date (January 1, 2017)).
4. Effective July 1, 2016, in all areas except the nine Round 1 CBAs, your MACs will process and pay claims for wheelchair base codes K0835 – K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.
5. Effective January 1, 2017 in all areas including the Round 1 Re-compete CBAs, your MACs will process and pay claims for the codes K0835 – K0864): E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 (when applicable) on a lump sum purchase basis when used with complex rehabilitative power wheelchairs.
6. When Home Health/Hospice providers (HHHs) bill codes E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070 and E0955 for services outside a competitive bid area on or after July 1, 2016, payment will be made on a capped rental basis.
7. When HHHs bill E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955 for services outside a competitive bid area on or after July 1, 2016, MACs will process such claims on a lump sum purchase basis, where applicable, when used with a complex rehabilitative wheelchair base (K0835-K0864).

Additional Information

The official instruction, CR 8822 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1626OTN.pdf on the CMS website.

Adjusted DMEPOS Fee Schedule Amounts Using Information from the National CBP

MLN Matters® Number: MM9239
Related Change Request (CR) #: CR 9239
Related CR Release Date: September 11, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3350CP
Implementation Date: January 4, 2016

Provider Types Affected

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

Provider Action Needed

The adjusted fee schedule amounts for the applicable Healthcare Common Procedure Coding System (HCPCS) codes will be used to pay claims with dates of service on or after January 1, 2016, and will be included in the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule files beginning January 1, 2016.

Section1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the Competitive Bidding Program (CBP). Section 1842(s)(3(B) of the Social Security Act (the Act) provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. Change Request (CR) 9239 implements the adjusted DMEPOS fees schedule from the CBP. Make sure that your billing staffs are aware of the adjusted DMEPOS fee schedule amounts from the CBP.

Background

Medicare payment for most DMEPOS is based on either fee schedules or single payment amounts (SPAs) established under the CBP in certain specified geographic areas, as mandated by 1847(a) and (b) the Act.

Competitive bidding was phased in with the Round 1 Rebid contracts beginning January 1, 2011, in 9 competitive bid areas (CBAs). Contracts for the Round 1 Rebid expired on December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompete contracts for the DMEPOS CBP at least once every 3 years. The same 9 CBAs were rebid under the Round 1 Recompete with the contracts and process claims with date of service beginning January 1, 2014. Competitive bidding was phased in with the Round 2 contracts beginning July 1, 2013, in 100 additional CBAs. Beginning with the Round 2 Recompete scheduled to take effect on July 1, 2016, CBAs covering more than one state will be subdivided into CBAs that do not cross state lines, resulting in an increase in the total number of CBAs.

The product categories and HCPCS codes included in each Round of the CBP are available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the Competitive Bidding Implementation Contractor (CBIC) website.

Section1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the CBP. Section 1842(s)(3(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for using information from the CBP to adjust the fee schedule amounts for DME and enteral nutrition are set forth in regulations at 42 Code of Federal Regulations (CFR) 414.210(g). There are three general methodologies:

- Adjustment of fee schedule amounts for areas within the contiguous United States, with a special rule for rural areas;
- Adjustment of fee schedule amounts for areas outside the contiguous United States; and
- Adjustment of fee schedule amounts for certain items for all areas in cases where the items have been included in competitive bidding programs in 10 or fewer CBAs.

Fee Schedule Amounts for Areas within the Contiguous United States

This methodology for adjusting the fee schedule amounts uses the average of SPAs from CBPs located in eight different regions of the contiguous United States to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or RSPAs are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (that is, those included in more than 10 CBAs).

There is also a special rule for areas within the contiguous United States that are designated as rural areas. The fee schedule amounts for these areas will be adjusted to equal the national ceiling amounts described above. Regulations at §414.202 define a rural area to be a geographical area represented by a postal ZIP Code where at least 50 percent of the total geographical area of the ZIP Code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

As a result of these adjustments, the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts.

Fee Schedule Amounts for Areas outside the Contiguous United States

Areas outside the contiguous United States (noncontiguous areas such as Alaska, Guam, Hawaii) are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States.

Fee Schedule Amounts for Items Included in 10 or Fewer CBAs

DME items included in 10 or fewer CBAs are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applied to all areas (non-contiguous and contiguous).

Phasing In and Updating Fee Schedule Amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016 through June 30, 2016, so that the fee schedule amount is based on a blend of 50 percent of the current fee schedule amounts (the fee schedule amounts that would have gone into effect on January 1, 2016, if they had not been adjusted based on information from the CBP) and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the fee schedule is based on 100 percent of the adjusted fee schedule amount.

In most cases, the adjusted fee schedule amounts will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where SPAs from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment is made (for example, 2016) and for each subsequent year (for example, 2017, 2018).

The DME MAC and Part B MAC DMEPOS fee schedule file shall be adjusted to include the rural fee and rural fee indicator and these changes will be reflected in the file format and data requirements specified in Chapter 23, Section 60.1 of the "Medicare Claims Processing Manual." Similarly, the Fiscal Intermediary (FI) DMEPOS fee schedule file format, outlined in Chapter 23, Section 50.2 of the "Medicare Claims Processing Manual," will be updated to include the rural fee and rural fee indicator. Beginning January 1, 2016, the DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodology as well as codes that are not subject to the adjustments. The DMEPOS fee schedule file will continue to be updated and available for download on a quarterly basis as necessary.

The parenteral and enteral nutrition (PEN) fee schedule file will accommodate adjusted fees for the enteral HCPCS codes that are state specific. The PEN file layout is outlined in Chapter 23, Section 70.1 of the "Medicare Claims Processing Manual."

Additional Information

The official instruction, CR 9239 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3350CP.pdf on the CMS website.

DMEPOS CBP – April 2016 Quarterly Update

MLN Matters ® Number: MM9477
Related Change Request (CR) #: CR9477
Related CR Release Date: December 18, 2015
Effective Date: April 1, 2016
Related CR Transmittal #: R3424CP
Implementation Date: April 4, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9477 provides the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) April 2016 quarterly update. CR9477 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

Note that quarterly updates are also available at Updates Link on the Internet. At that site, click on the "Quarterly Updates" link on the left of the page.

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.

Additional Information

The official instruction, CR 9477 issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3424CP.pdf on the CMS website.

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

Completion of Certifications of Medical Necessity – Annual Reminder

Joint DME MAC Publication

Dear Physician:

Certificates of Medical Necessity, commonly known as CMNs, are documents used by the DME MACs to assist in gathering information about the medical necessity of an item. It is your responsibility to determine both, the medical need for, and the utilization of, all healthcare services.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are your partners in caring for your patient. They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient's treatment plan, completing the CMN accurately and in a timely manner helps insure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p) (4) of the Act provides that:

[i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.

Printable copies of CMNs and DIFs are available on the CMS website at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html. To find the CMN/DIF you are looking for, enter the name or form number in the "Filter On" field. For instance, if you are searching for the Oxygen CMN, enter the word "oxygen" or "484".

Remember, everyone has tight cash flow these days – help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Sincerely,

Peter J. Gurk, M.D.

Coverage and Coding – New Oral Antiemetic Drug Akynzeo® – Revised

Joint DME MAC Publication

This is a revision to previous version (with the same title), published May 28, 2015 and adds the new HCPCS code for Akynzeo®.

The U.S. Food and Drug Administration approved Akynzeo® on October 10, 2014. Akynzeo® is a combination medication used to treat nausea and vomiting in patients undergoing cancer chemotherapy.

Akynzeo® is a fixed combination capsule comprised of two drugs, oral palonosetron (a 5HT3 antagonist) and netupitant (a NK-1 antagonist). The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Akynzeo® and determined that it is eligible for inclusion in the DME MAC Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) Local Coverage Determination (LCD), effective for claims with dates of service on or after October 10, 2014.

The use of the oral anti-emetic 3-drug combination of an FDA-approved oral NK-1 antagonist and an oral 5HT3 antagonist, in combination with dexamethasone, is covered if, in addition to meeting the statutory coverage criteria specified in the related Policy Article, they are administered to beneficiaries who are receiving one or more of the anti-cancer chemotherapeutic agents listed in the LCD regarding oral anti-emetic coverage.

For dates of service prior to July 1, 2015, claims for Akynzeo® must be billed using HCPCS code:

> Q0181 - UNSPECIFIED ORAL DOSAGE FORM, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR A IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN

For dates of service on or after to July 1, 2015 through December 31, 2015, claims for Akynzeo® must be billed using HCPCS code:

> Q9978 - NETUPITANT PALONOSETRON ORAL NETUPITANT 300 MG AND PALONOSETRON 0.5 MG, ORAL

For dates of service on or after January 1, 2016, claims for Akynzeo® must be billed using HCPCS code:

> J8655 - NETUPITANT 300 MG AND PALONOSETRON 0.5 MG

Akynzeo® (Q0181 or Q9978 or J8655) must be billed on the same claim with dexamethasone (J8540) to qualify for consideration of coverage. There must be no unbundling of the netupitant and palonosetron combination in Akynzeo®.

If Akynzeo® (Q0181 or Q9978 or J8655) and dexamethasone (J8540) are used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of the LCD regarding oral antiemetics, a KX modifier must be added to each code. In addition to the diagnosis code corresponding to the beneficiary's cancer diagnosis, claims for these drugs must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy.

Any claims for code Q0181 must be accompanied by the name of the drug, the manufacturer, the dosage strength dispensed, the number of capsules and frequency of administration during the covered time period (24-48 hours) as specified on the order. (Note the time span of coverage remains as stated in the LCD). This information should be entered in the narrative field of an electronic claim.

If Akynzeo® (Q0181 or Q9978 or J8655) and dexamethasone (J8540) are not used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of this policy, the GA or GZ modifier must be added to the claim lines for Q0181 and J8540. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

Please refer to the DME Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) Local Coverage Determination and related Policy Article for further information on coverage, documentation and coding.

2016 Ask the Contractor Teleconferences

If you have a question on your mind and are not sure who to ask, the Ask the Contractor Teleconferences (ACTs) are your opportunity to speak directly to Noridian DME. Knowledgeable Noridian staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and include the answer in the posted minutes.

Upcoming 2015 ACTs: 3 p.m. CT

- March 10
- June 9
- September 8
- December 8

Toll Free number: (800) 230-1074

After placing the call for the ACT, suppliers need to provide the following:

- Conference Name: DME Jurisdiction D Ask the Contractor Teleconference
- Name
- Name of the organization represented
- State

Break in Service and Break in Need – DME on Demand

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Break in Service/Continued Use
- Break in Service/Continued Use Example
- Break in Need
- Break in Need Example
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Heating Pads and Heat Lamps – Coding

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Coding
- A9273
- E0225 and E0239
- E0210
- E0215
- E0217

- E0249
- Heating Pads
- Pricing, Data Analysis and Coding (PDAC)
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Heating Pads and Heat Lamps – Coverage Criteria

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Coverage
- Elecric Heating Pad
- Noncoverage of Heating Pad
- E0215 and E0217
- Heat Lamps
- Replacements
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Hospice

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Part A Benefits
- Eligibility
- Covered Services
- Billing Covered Services
- Capped Rental Hospice

Viewing Presentation

To view this presentation, go to the Education Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – How to Pass a Medical Review

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Suppliers – Prevent Denials
- Familiarity with Requirements
- Medical Necessity
- Specialize Your Intake Process
- Standard Documentation Requirements
- Submitting Documentation
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Osteogenesis Stimulators: Coding and Billing

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Description
- Coding
- Inclusive Components
- Pricing, Data Analysis and Coding (PDAC)
- ICD Diagnosis Codes
- Certificate of Medical Necessity (CMN)
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Participating Vs. Non-Participating

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Participating/Non-Participating
- Participating Supplier
- Non-Participating Supplier
- Open Enrollment Each Year

- Participating Suppliers Directory
- Assignment Agreement

Viewing Presentation

To view this presentation, go to the Education Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Patient Lifts: Billing Reminders

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Billing Reminders
- Capped Rental Items
- Inexpensive or Routinely Purchased
- Capped Rental and Inexpensive and Routinely Purchased (IRP) Notification
- Bundling
- Modifiers
- Multi-Positional Patient Transfer System
- Pricing, Data Analysis and Coding (PDAC)
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Patient Lifts: Coding

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Coding
- Multi-Positional & Heavy Duty/Bariatric Lifts
- E0639
- E0640
- E1035 or E1036
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Patient Lifts: Coverage Criteria

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Coverage
- Patient Lift
- Multi-Positional Patient Transfer System
- E1035 and E1036
- Accessories
- Non-Covered Items
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Patient Lifts: Upgrades

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Upgrades
- Upgrades Charging for the Difference
- Upgrade Not Charging for Difference
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Prepay Reviews: Submission and Denials

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Pre-Payment Reviews
- CERT & Reviews
- Notifiacation of Review
- ADR Submissions
- Why Did I Receive a Denial
- Understanding Denial
- No Response to ADR Request
- Example of Remittance Advice

- Appeals/Redeterminations
- Resources

Viewing Presentation

To view this presentation, go to the Education Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – PDAC Contractor

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- What is Pricing, Data Analysis and Coding (PDAC)?
- PDAC Website Homepage
- PDAC Website Navigation
- PDAC Contact Information
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

GA, GZ, GX, EY and GY Modifiers – DME on Demand

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Modifier Usage with Advance Beneficiary Notices of Noncoverage (ABNs)
- Liability Modifiers – GA and GZ
- Liability Modifier - GX
- EY Modifier
- EY Modifier with Statutory Requirements
- GY Modifier
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

Medicare Secondary Payer – DME on Demand

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Medicare Secondary Payer (MSP)
- Responsibilities as Medicare Provider
- Questions to Ask
- Capped Rentals
- MSP Claim Filing Tips
- Analysis of Common MSP Coverage Situations
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

Supplier Reminders – DME on Demand

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- National Supplier Clearinghouse (NSC) Changes
- Intake
- Local Coverage Determinations (LCDs) and Policy Articles (PAs)
- Advance Beneficiary Notices of Noncoverage (ABNs)
- Proof of Delivery (POD)
- Modifiers
- Upgrades
- Documentation Requests
- Front End Edits Claim Rejections
- Front End Errors Certificates of Medical Necessity (CMNs)
- Resources
- Denials
- Appeals

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

EDUCATIONAL

Understanding Front End Errors for CMNs

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Common Electronic Data Interchange (CEDI)
- Certificates of Medical Necessity (CMN) Reject Listing Report 716006
- Rejected CMNS
- What's Included on the Reject Listing Report
- Key to the Report
- Tips for Correct Transmission
- Error Code 3030
- Error Code 3031
- Error Code 3031 - Resolution
- Error Code 3032
- Error Code 3032 - Resolution
- Error Code 3047
- Error Code 3048
- Error Code 3052
- Resources

Viewing Presentation

To view this presentation, go to the Education Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

ENROLLMENT

Provider Enrollment Revalidation – Cycle 2

MLN Matters® Number: SE1605

Provider Types Affected

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

Provider Action Needed

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

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

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

Background

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

What's ahead for your next Medicare enrollment revalidation?

Established Due Dates for Revalidation

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

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

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

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

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

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

Large Group Coordination

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

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

Unsolicited Revalidation Submissions

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

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

Submitting Your Revalidation Application

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

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

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

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

To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do.

PECOS allows you to review information currently on file and update and submit your revalidation via the Internet. Once completed, YOU MUST electronically sign the revalidation application and upload any supporting documents or print, sign, date, and mail the paper certification statement along with all required supporting documentation to your appropriate MAC IMMEDIATELY.

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

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

Getting Access to PECOS:

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

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

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

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

Deactivations Due to Non-Response to Revalidation or Development Requests

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

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

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

Revalidation Timeline and Example

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

Action	Timeframe	Example
Revalidation list posted	Approximately 6 months prior to due date	March 30, 2016
Issue large group notifications	Approximately 6 months prior to due date	March 30, 2016
MAC sends email/letter notification	75 – 90 days prior to due date	July 2 - 17, 2016

Action	Timeframe	Example
MAC sends letter for undeliverable emails	75 – 90 days prior to due date	July 2 - 17, 2016
Revalidation due date		September 30, 2016
Apply payment hold/issue reminder letter (group members)	Within 25 days after due date	October 25, 2016
Deactivate	60 – 75 days after due date	November 29 – December 14, 2016

Application Fees

Institutional providers of medical or other items or services and suppliers are required to submit an application fee for revalidations. The application fee is $554.00 for Calendar Year (CY) 2016. CMS has defined "institutional provider" to mean any provider or supplier that submits an application via PECOS or a paper Medicare enrollment application using the CMS-855A, CMS-855B (except physician and non-physician practitioner organizations), or CMS-855S forms.

All institutional providers (that is, all providers except physicians, non-physicians practitioners, physician group practices and non-physician practitioner group practices) and suppliers who respond to a revalidation request must submit the 2016 enrollment fee (reference 42 CFR 424.514) with their revalidation application. You may submit your fee by ACH debit, or credit card. To pay your application fee, go to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do and submit payment as directed. A confirmation screen will display indicating that payment was successfully made. This confirmation screen is your receipt and you should print it for your records. CMS strongly recommends that you include this receipt with your uploaded documents on PECOS or mail it to the MAC along with the Certification Statement for the enrollment application. CMS will notify the MAC that the application fee has been paid. Revalidations are processed only when fees have cleared.

Summary

- CMS will post the revalidation due dates for the upcoming revalidation cycle on http://go.cms.gov/MedicareRevalidation for all providers/suppliers. This list will be refreshed periodically. Check this list regularly for updates.
- MACs will continue to send revalidation notices (either by email or mail) within 2-3 months prior to your revalidation due date. When responding to revalidation requests, be sure to revalidate your entire Medicare enrollment record, including all reassignment and practice locations. If you have multiple reassignments/billing structures, you must coordinate the revalidation application submission with all parties.
- If a revalidation application is received but incomplete, the MACs will develop for the missing information. If the missing information is not received within 30 days of the request, the MACs will deactivate the provider/supplier's billing privileges.
- If a revalidation application is not received by the due date, the MAC may place a hold on your Medicare payments and deactivate your Medicare billing privileges.
- If billing privileges are deactivated, a reactivation will result in the same PTAN but an interruption in billing during the period of deactivation. This will result in a gap in coverage.
- If the revalidation application is approved, the provider/supplier will be revalidated and no further action is needed.

Additional Information

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

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

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

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

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

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

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

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

MLN Matters® Number: SE1128 Revised

This article was revised on February 4, 2016, to include updated information for 2016 and a correction to the second sentence in paragraph 2 under Important Clarifications Concerning QMB Balance Billing Law on page 3. All other information is the same.

Provider Types Affected

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

What you Need to Know

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

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

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

Background

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

Balance Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers from balance billing a QMB beneficiary under any circumstances. See Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997. (Please note, this section of the Act is available at http://www.ssa.gov/OP_Home/ssact/title19/1902.htm on the Internet.)

QMB is a Medicaid program for Medicare beneficiaries that exempts them from liability for Medicare cost-sharing. State Medicaid programs may pay providers for Medicare deductibles, coinsurance and copayments. However, as permitted by federal law, States can limit provider reimbursement for Medicare cost-sharing under certain circumstances. See the chart at the end of this article for more information about the QMB benefit.

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

Inappropriate Balance Billing Persists

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

Important Clarifications Concerning QMB Balance Billing Law

Be aware of the following policy clarifications to ensure compliance with QMB balance billing requirements. First, know that all original Medicare and MA providers-- not only those that accept Medicaid -- must abide by the balance billing prohibitions.

In addition, QMB individuals retain their protection from balance billing when they cross state lines to receive care. Providers cannot charge QMB individuals even if the patient's QMB benefit is provided by a different State than the State in which care is rendered.

Finally, note that QMBs cannot choose to "waive" their QMB status and pay Medicare cost-sharing. The federal statute referenced above supersedes Section 3490.14 of the "State Medicaid Manual," which is no longer in effect.

Ways to Improve Processes Related to QMBs

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

1. Determine effective means to identify QMB individuals among your patients. Find out what cards are issued to QMB individuals so you can in turn ask all your patients if they have them. Learn if you can query state systems to verify QMB enrollment among your patients. If you are a Medicare Advantage provider contact the plan to determine how to identify the plan's QMB enrollees.
2. Discern what billing processes apply to seek reimbursement for Medicare cost-sharing from the States in which you operate. Different processes may apply to original Medicare and MA services provided to QMB beneficiaries. For original Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination & Recovery Center (BCRC) to automatically receive Medicare-adjudicated claims.

If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare Remittance Advice.

Understand the processes you need to follow to request reimbursement for Medicare cost-sharing amounts if they are owed by your State. You may need to complete a State Provider Registration Process and be entered into the State payment system to bill the State.

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

QMB Eligibility and Benefits

Dual Eligibility	Eligibility Criteria	Benefits
Qualified Medicare Beneficiary (QMB only)	Resources cannot exceed $7,280 for a single individual or $10,930 in 2015 for an individual living with a spouse and no other dependents. Income cannot exceed 100% of the Federal Poverty Level (FPL) +$20 ($1,001/month – Individual $1,348/month – Couple in 2015). **Note:** These guidelines are a federal floor. Under Section 1902 (r)(2) of the Social Security Act, states can effectively raise these limits above these baseline federal standards.	Medicaid Pays Medicare Part A and B premiums, deductibles, co-insurance and co-pays to the extent required by the State Medicaid Plan. • Exempts beneficiaries from Medicare cost-sharing charges • The State may choose to pay the Medicare Advantage (Part C) premium.
QMB Plus	Meets all of the standards for QMB eligibility as described above, but also meets the financial criteria for full Medicaid coverage	Provides all benefits available to QMBs, as well as all benefits available under the State Plan to a fully eligible Medicaid recipient

Additional Information

For more information about dual eligible categories and benefits, please visit http://www.medicare.gov/Publications/Pubs/pdf/10126.pdf on the Internet. Also, for more information about QMBs and other individuals who are dually eligible to receive Medicare and Medicaid benefits, please refer to the Medicare Learning Network® publication titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles)," which is available on the CMS website.

Implementation of Fingerprint-Based Background Checks – Revised

MLN Matters® Number: SE1417 Revised

This article was revised on January 27, 2016, to update language in the article and to emphasize affected providers and suppliers in the Caution Section.

Provider Types Affected

This MLN Matters® Special Edition article is intended for all providers and suppliers who submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to announce the implementation of fingerprint-based background checks as part of enhanced enrollment screening provisions contained in Section 6401 of the Affordable Care Act.

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. **A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a high risk provider or supplier.** Note that the high level of risk category applies to providers and suppliers who are newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers or Home Health Agencies (HHA). It also applies to providers and suppliers who have been elevated to the high risk category. CMS may adjust a particular provider or supplier's screening level from "limited" to "high" or "moderate" to "high" if any of the following occur:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any Federal Health Care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or

CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

See the Background and Additional Information Sections of this article for further details.

Background

As part of the enhanced enrollment screening provisions contained in the Affordable Care Act (see http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf), the Centers for Medicare & Medicaid Services (CMS) implemented fingerprint-based background checks. The fingerprint-based background checks will be used to detect bad actors who are attempting to enroll in the Medicare program and to remove those currently enrolled. Once fully implemented, the fingerprint-based background check will be completed on all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high risk category. A 5 percent or greater owner includes any individual that has any partnership (general or limited) in a provider or supplier. Fingerprint- based background checks are also required for any provider or supplier who has been elevated to the high risk category for any of the following reasons:

- CMS has imposed a payment suspension within the last 10 years;
- Has been excluded from Medicare by the OIG;
- Has had billing privileges revoked by CMS within the previous 10 years;
- Has been excluded from any Federal Health Care program;
- Has been subject to any final adverse action, in the previous 10 years;
- Has been terminated or is otherwise precluded from billing Medicaid; or
- CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

Please refer to 42 CFR 424.518(c)(3) at http://www.ecfr.gov/cgi-bin/text-idx?SID=a39ae0804106965d82b5ae6413ba550e&node=42:3.0.1.1.11.12.5.11&rgn=div8 on the Internet and the "Medicare Program Integrity Manual" (Chapter 15 (Medicare Enrollment), Section 15.19.2.1C (Screening Categories-Background-High)) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c15.pdf on the CMS website.

The fingerprint-based background checks will be applied to providers and suppliers in the high level of risk category, which includes newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, Home Health Agencies (HHA) and providers and suppliers who have been elevated to the high risk category in accordance with enrollment screening regulations.

The fingerprint-based background check implementation has been phased in beginning in 2014. Affected providers and suppliers will receive notification of the fingerprint requirements from their MAC. The MAC will send a notification letter to the affected providers or suppliers listing all 5 percent or greater owners who are required to be fingerprinted. The notification letter will be mailed to the provider or supplier's correspondence address and the special payments address on file with Medicare. Generally, an individual will be required to be fingerprinted only once, but CMS reserves the right to request additional fingerprints if needed.

The relevant individuals will have 30 days from the date of the notification letter to be fingerprinted. If the provider or supplier finds a discrepancy in the ownership listing, the provider or supplier should contact their MAC immediately to communicate the discrepancy and take the appropriate action to update the enrollment record to correctly reflect the ownership information. The notification letter will identify contact information for the Fingerprint-Based

Background Check Contractor (FBBC). The relevant individual(s) are required to contact the FBBC prior to being fingerprinted to ensure the fingerprints are accurately submitted to the Federal Bureau of Investigation (FBI) and results are properly returned to CMS. Providers/suppliers may contact the FBBC by telephone or by accessing the FBBC's website. Contact information for the FBBC will be provided in the notification letter received from the MAC. Once contacted, the FBBC will provide at least three fingerprint locations convenient to the relevant individual's location. One of these locations will be a local, state, or federal law enforcement facility.

The relevant individuals who are required to undergo the fingerprint-based background check will incur the cost of having their fingerprints taken, and the cost may vary depending on location. **Once an individual has submitted his/her fingerprints, if that individual is subsequently required to undergo a fingerprint-based background check in accordance with 42 CFR 424.518(c), CMS will, to the extent possible, rerun the fingerprint-based background check rather than requiring resubmission of fingerprints.** You can review 42 CFR 424.518(c) at http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.11&rgn=div8 on the Internet.

Fingerprinting can be completed on the FD-258 form or electronically at certain locations. CMS strongly encourages all required applicants to provide electronic fingerprints, but CMS will accept the FD-258 card instead. If the FD-258 form is submitted, the FBBC will convert the paper form to electronic submission to the FBI. You can review the FD-258 form at https://www.fbi.gov/about-us/cjis/identity-history-summary-checks/fd-258-1 on the Internet.

Once the fingerprint process is complete, the fingerprints will be forwarded to the FBI for processing. Within 24 hours of receipt, the FBI will compile the background history based on the fingerprints and will share the results with the FBBC. CMS, through the FBBC, will assess the law enforcement data provided for the fingerprinted individuals. The FBBC will review each record and provide a fitness recommendation to CMS. CMS will assess the recommendation and make a final determination.

All fingerprint data will be stored according to:

- Federal requirements;
- FBI Security and Management Control Outsourcing Standards for Channelers and Non-Channelers; and
- The FBI Criminal Justice Information Services (CJIS) Security Policy.

The FBBC will maintain Federal Information Systems Management Act (FISMA) certification and comply with the FBI (CJIS) Security Policy. All data will be secured in accordance with the Privacy Act of 1974 and the FBI CJIS Security Policy.

CMS will rely on existing authority to deny enrollment applications and revoke existing

Medicare billing privileges per 42 CFR §424.530(a) and §424.535(a) (http://www.ecfr.gov/cgi-bin/text-idx?SID=f14b263d1175a355d736e9f38f3a6baf&node=42:3.0.1.1.11.12.5.15&rgn=div8) if an individual who maintains a 5 percent or greater direct or indirect ownership interest in a provider or supplier has submitted an enrollment application that contains false or misleading information. Providers or suppliers will be notified by CMS if the assessment of the fingerprint based background check results in the denial of its enrollment application or revocation of its existing Medicare billing privileges.

Additional Information

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

Correct Coding – NOC Codes for Enteral (B9998) and Parenteral (B9999) Nutrition

DME MAC Joint Publication

Recent claims analysis of the "Not Otherwise Classified" (NOC) codes used with enteral and parenteral nutrition claims identified errors in the use of these codes. This article will discuss the correct use of these NOC codes. The codes are:

- B9998 NOC FOR ENTERAL SUPPLIES
- B9999 NOC FOR PARENTERAL SUPPLIES

Correct coding requires the use of a specific HCPCS code for an item when a specific code exists. Use of a NOC code in place of a specific code represents incorrect coding.

Enteral Nutrition

The analysis of B9998 reviewed 909 claim lines finding that:

- 628 claim lines were identified as extension tubing.
- 61 claim line descriptions could not be deciphered to identify a specific item.
- 20 claim lines contained B9002 with MS, RR and/or KJ modifiers.
- 50 claim lines were identified as "per diem charges"

These claim lines are incorrectly coded.

The Enteral Nutrition Related Policy Article CODING GUIDELINES describe the requirements applicable to supplies used with enteral nutrition. The applicable supply allowance codes are:

- B4034 ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
- B4035 ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
- B4036 ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE

From the Coding Guidelines:

The codes for enteral feeding supplies (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the beneficiary for one day. Codes B4034-B4036 describe a daily supply fee rather than a specifically defined "kit". Some items are changed daily; others may be used for multiple days. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors. These supplies include, but are not limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc. These items must not be separately billed using the miscellaneous code (B9998) or using specific codes for dressings or tape. The use of individual items may differ from beneficiary to beneficiary and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding. (Emphasis added)

The supply allowance codes B4034-B4036 are all-inclusive, other than the feeding tube. Extension tubing and "per diem" charges for supplies must not be unbundled. "Per diem" charges for professional services associated with the provision of enteral nutrition likewise are not separately billable. Payment for professional services is included in the payment for all DMEPOS items.

Use of a NOC code to bill for an enteral pump is incorrect coding. B9000 (ENTERAL NUTRITION INFUSION PUMP - WITHOUT ALARM) and B9002 (ENTERAL NUTRITION INFUSION PUMP - WITH ALARM) are separately billable, specific HCPCS codes to be used for these items.

Suppliers are reminded to be sure that the submitted product information clearly identifies the item for which the NOC code is being used.

Parenteral Nutrition

The Analysis of B9999 reviewed 1196 claim lines finding that:

- 754 claim lines were identified as "per diem charges"
- 313 claim lines were identified as an IV securement device. An IV securement device is used to secure an IV to the beneficiary to ensure it is not dislodged.
- 26 claim lines were identified as the BioPatch®. The BioPatch® is a round antibacterial dressing with a slit to fit around the IV site in order to prevent infection.

These claim lines are incorrectly coded.

The applicable supply allowance codes for parenteral nutrition are:

- B4220 PARENTERAL NUTRITION SUPPLY KIT; PREMIX, PER DAY
- B4222 PARENTERAL NUTRITION SUPPLY KIT; HOME MIX, PER DAY
- B4224 PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY

The supply allowance codes B4220-B4224 are all-inclusive. Intravenous securement devices, the BioPatch® dressing, and "per diem" charges for supplies must not be unbundled. "Per diem" charges for professional services associated with the provision of parenteral nutrition likewise are not separately billable. Payment for professional services is included in the payment for all DMEPOS items.

Refer to the Enteral Nutrition and Parenteral Nutrition LCDs and their related Policy Articles for additional information.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

DME on Demand – Completing the DIF for Enteral Nutrition

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- DME Information Form (DIF)
- New Initial DIF for Nutrients
- New Initial DIF for Pump
- Revised DIF for Nutrients
- Recertification DIF
- Supply Item/Service Procedure Code(s)
- DIF Questions
- Supplier Attestation, Signature, Date
- Resources

Viewing Presentation

To view this presentation, go to the Education Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

ENTERAL AND PARENTAL NUTRITION

DME on Demand – Completing the DIF for Parenteral Nutrition

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EXTERNAL INFUSION PUMPS

Coverage and Correct Coding of Blincyto™ – Revised

Joint DME MAC Publication

Posted February 20, 2015

Revised January 7, 2016

This is a revision to a previous version published February 20, 2015, and adds the new HCPCS code for blinatumomab.

On December 03, 2014, the FDA gave accelerated approval for Blinatumomab (Blincyto™) for the treatment of Philadelphia negative relapsed/refractory acute lymphoblastic leukemia. Blincyto™ is a bispecific CD19-directed CD3 T-cell engager that activates endogenous T cells when bound to the CD19-expressing target cell (B cells). Activation of the immune system results in release of inflammatory cytokines. The FDA-approved schedule is for 6-week cycles, for a total five cycles.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Blincyto™ and determined that it is eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD).

Blincyto™ can be administered in multiple inpatient and outpatient settings. However, the DME MACs will only process claims for blinatumomab when it is administered to a Medicare beneficiary every 48 hours in an unsupervised home setting, with drug cassette exchanges that do not require supervision performed at a hospital/outpatient infusion facility. Claims to the DME MACs for Blincyto™ administered in any other setting will be rejected as wrong jurisdiction.

Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

This information must be entered in the narrative field of an electronic claim (NTE 2300 or NTE 2400 of an electronic claim) or Item 19 of a paper claim.

Claims for Blincyto™ for dates of service on or after December 03, 2014, through December 31, 2015, must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME).

Claims for Blincyto™ for dates of service on or after January 1, 2016, must be submitted using HCPCS code J9039 (INJECTION, BLINATUMOMAB, 1 MICROGRAM).

Please refer to the External Infusion Pump LCD and related Policy Article for additional coverage, coding and documentation requirements.

For questions about correct coding, contact the Pricing, Data Analysis, and Coding contractor (PDAC) at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

Coverage and Correct Coding of Duopa® (Levodopa-Carbidopa Enteral Suspension) – Revised

Joint DME MAC Publication

Posted February 20, 2015

Revised January 7, 2016

This is a revision to a previous version published February 20, 2015, and adds the new HCPCS code for Duopa®.

On January 09, 2015, Duopa® (AbbVie) was approved by the FDA. Duopa® is an enteral-suspension combination of levodopa and carbidopa, and is indicated for the treatment of Parkinson's disease (PD). Duopa® is administered as a continuous 16-hour infusion into the jejunum through a percutaneous endoscopic gastrostomy-jejunal tube (PEG-J), using a CADD®-Legacy 1400 portable infusion pump.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated Duopa® and determined that it is eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD). Refer to the External Infusion Pump LCD and Policy Article for specific coverage requirements.

Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information on each claim:

- Name of Drug
- Dosage Strength
- Amount Dispensed (e.g., total mg)
- Administration Instructions

This information must be entered in the narrative field of an electronic claim (NTE 2300 or NTE 2400 of an electronic claim) or Item 19 of a paper claim.

Claims for Duopa® for dates of service on or after January 09, 2015, through December 31, 2015, must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME).

Claims for Duopa® for dates of service on or after January 01, 2016, must be submitted using the HCPCS code J7340 (CARBIDOPA 5 MG/LEVODOPA 20 MG ENTERAL SUSPENSION).

Establishment of the transabdominal port with a PEG-J is performed under endoscopic guidance by a gastroenterologist or other healthcare provider experienced in this procedure. The PEG-J is considered a supply provided incident to a physician's service, and claims for this item are processed by the A/B MAC contractor. Claims to the DME MAC for the PEG-J will be rejected as wrong jurisdiction.

Refer to the, the External Infusion Pump LCD and related Policy Article for additional coverage, coding and documentation requirements.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

Coverage and Correct Coding of HYQVIA (Immune Globulin Infusion (Human) 10%, with Recombinant Human Hyaluronidase) – Revised

Joint DME MAC Publication

Revised January 7, 2016

Revised July 30, 2015

Posted December 18, 2014

This is a revision to a previous version published July 30, 2015 and adds the new HCPCS code for HYQVIA.

On September 12, 2014, HYQVIA (Baxter Healthcare) was approved by the FDA. HYQVIA is a subcutaneously administered immune globulin 10% (Human) with recombinant human hyaluronidase, and is indicated for the treatment of Primary Immunodeficiency (PI) in adults.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated HYQVIA and determined that it is eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD).

HYQVIA is administered using a programmable variable infusion pump (HCPCS code E0781), that is capable of infusing a patient's therapeutic dose at infusion rates of up to 300 mL/hr/site.

Coverage is available for claims with dates of service on or after September 12, 2014 when all of the following requirements have been met:

- The criteria for Subcutaneous Immune Globulin as specified in the External Infusion Pump LCD are met, and
- HYQVIA is administered subcutaneously through an E0781 pump that is pre-programmed, and
- The E0781 pump is delivered to the Medicare beneficiary in a "locked mode" i.e., the patient is unable to self-adjust the infusion rate.

The medical record must contain sufficient information to clearly demonstrate that the beneficiary meets all of the requirements specified above.

Administration of HYQVIA requires a gradual increase in the infusion rate at the beginning of each infusion. This infusion rate ramp-up is patient-specific and must be determined under medical supervision over the course of several infusions of HYQVIA. Once the infusion rate ramp-up specification(s) have been determined, they can be programmed into an appropriate E0781 pump. There is no coverage under the Durable Medical Equipment Benefit for equipment, drugs and infusions supplies used during these initial doses as they are considered as incident to the required professional supervision. Claims to the DME MAC for the pump, drugs and supplies administered in this scenario will be rejected as wrong jurisdiction.

Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information on each claim:

- Name of Drug
- Manufacturer name
- Dosage Strength

This information must be entered in the narrative field of an electronic claim (NTE 2300 or NTE 2400 of an electronic claim) or Item 19 of a paper claim.

Claims for HYQVIA for dates of service from September 12, 2014, through December 31, 2015, must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME).

Claims for HYQVIA with dates of service on or after January 1, 2016, must be submitted using the HCPCS code J1575 (INJECTION, IMMUNE GLOBULIN/HYALURONIDASE, (HYQVIA), 100 MG IMMUNEGLOBULIN).

Refer to the, the External Infusion Pump LCD and related Policy Article for additional coverage, coding and documentation requirements.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

Coverage and Correct Coding of YONDELIS®

Joint DME MAC Publication

On October 23, 2015, the Food and Drug Administration (FDA) gave accelerated approval to YONDELIS® (trabectedin), a chemotherapy treatment for specific soft tissue sarcomas (STS) – liposarcoma and leiomyosarcoma – that cannot be removed by surgery (unresectable) or is advanced (metastatic). This treatment is approved for patients who previously received chemotherapy that contained anthracycline.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated YONDELIS® and determined that it is not eligible for inclusion in the Durable Medical Equipment (DME) External Infusion Pump Local Coverage Determination (LCD L33794).

Claims to the DME MACs for YONDELIS® whose administration is initiated in a provider's office will be rejected as wrong jurisdiction. Please consult with the appropriate A/B MAC for potential reimbursement under part B of the Medicare program.

Please refer to the External Infusion Pump LCD and related Policy Article for additional coverage, coding and documentation requirements.

For questions about correct coding, contact the Pricing, Data Analysis, and Coding contractor (PDAC) at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

DME on Demand – Completing the DIF for External Infusion Pumps

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- DME Information Form (DIF)
- Initial and Recertification DIF
- Revised DIF
- Supply Item/Service Procedure Code(s)
- DIF Questions
- Supplier Attestation , Signature, Date
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – External Infusion Pump Inotropic Drugs Revised: Coverage Criteria

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Revised Coverage Criteria
- Revised Inotropic Criteria
- Optimal GDMT
- Bridge Therapy
- Cardiac Evaluation
- Symptoms of Heart Failure
- Continued Evaluation
- Resources

Viewing Presentation

To view this presentation, go to the Education Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – External Infusion Pumps: Insulin Pump

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- E0784
- Insulin – J1817
- Specific Criteria for Insulin Pump
- Criterion A
- Criterion B
- Criterion C
- Criterion D
- Continued Coverage for Insulin Pump
- KX, GA, GZ Modifiers
- Resources

Viewing Presentation

To view this presentation, go to the Education Tools page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

LCD and Policy Article Revisions Summary for December 3, 2015

Outlined below are the principal changes to a DME MAC Local Coverage Determination (LCD) and a Policy Article (PA) that have been revised and posted. The policy included is Wheelchair Seating. Please review the entire LCD and related PA for complete information.

Wheelchair Seating

LCD

Revision Effective Date: 10/01/2015

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY
Added: ICD-10 codes for Stage 1 Pressure Ulcers

DOCUMENTATION REQUIREMENTS

Removed: Start date verbiage from Prescription Requirements
Added: Standard documentation language for dates on orders

Policy Article

Revision Effective Date: 10/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Start date verbiage from Prescription Requirements

Note: The information contained in this article is only a summary of revisions to the LCD and Policy Article. For complete information on any topic, you must review the LCD and/or Policy Article.

LCD and Policy Article Revisions Summary for December 17, 2015

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Nebulizers and Pneumatic Compression Devices. Please review each entire LCD and related PA for complete information.

Nebulizers

LCD

Revision Effective Date: 01/01/2016

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Deleted: HCPCS Code A7011 from Accessories tables

HCPCS CODES:
Deleted: HCPCS Code A7011
Added: HCPCS Code J7999

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Group 5 Codes:
Deleted: Code A7011 from the List of HCPCS codes
Group 7 Codes:
Added: ICD-10 Code E84.0 to Group 7 for J7608

DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/05/2015)

MISCELLANEOUS:
Deleted: Duplicative information about what is required on orders
Updated: HCPCS Code Q9977 cross-walked to J7999
Added: Standard product identification requirements for NOC codes

Policy Article

Revision Effective Date: 01/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Start date verbiage from Prescription Requirements (Effective 11/05/2015)

CODING GUIDELINES:
Updated: HCPCS Code Q9977 cross-walked to J7999

Pneumatic Compression Devices

LCD

Revision Effective Date: 12/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Trial requirements to reference "no significant improvement" rather than "no further improvement" for lymphedema, CVI, and for lymphedema extending on to the chest, trunk and/or abdomen
Removed: Word "Any" from trial requirements for lymphedema of the chest, trunk and/or abdomen

DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation language to remove start date verbiage from Prescription Requirements (Effective 11/05/2015)

Policy Article

Revision Effective Date: 12/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Start date verbiage from Prescription Requirements (Effective 11/05/2015)

Note: The information contained in this article is only a summary of revisions to the LCDs and Policy Articles. For complete information on any topic, you must review the LCD and/or Policy Article.

MOBILITY DEVICES

Correct Coding – Foot Boxes Used With Wheelchairs – Rescinded

The article titled "Correct Coding - Foot Boxes Used With Wheelchairs" published "Latest Updates" on February 11, 2016 has been rescinded. Additional review is being completed and the article will be reposted at a later date.

DME on Demand – Manual Wheelchair: Upgrades

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Upgrades
- Upgrade Charging for Difference – Obtain Advance Beneficiary Notice of Noncoverage (ABN)
- Upgrade Not Charging for Difference – No ABN
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

MOBILITY DEVICES

Manual Wheelchairs (HCPCS K0004) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code K0004. The final edit effectiveness results from July 2015 through January 2016 are as follows:

The K0004 review involved 52 claims, of which 34 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 64%.

The top reasons for denial were:

- Documentation received does not support that the beneficiary requires a high strength light weight wheelchair (K0004).
- Documentation received does not support that the beneficiary's home provides adequate access between rooms, maneuvering space and surfaces for use of the manual wheelchair that is provided.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation received does not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

For complete details, see Manual Wheelchairs (HCPCS K0004) Final Edit Effectiveness Results of Service Specific Prepayment Review.

Beneficiaries with Representative Payee Excluded from PMD Prior Authorization Demonstration are Eligible for ADMC

During recent analysis of power mobility device (PMD) Prior Authorization Requests (PARs) it was found that ineligible requests are often due to the beneficiary being excluded from the demonstration. It is important for suppliers to identify when a beneficiary has a representative payee on file, as these beneficiaries are not subject to the PMD Prior Authorization process. Therefore, a 25% reduction in payment is not applied when these claims are submitted.

For more information, see the Prior Authorization web page.

NEBULIZERS

Nebulizer (HCPCS J7682, J7686, Q4074) Notification of Service Specific Prepayment Probe Review

Noridian Jurisdiction D, DME MAC, Medical Review will be initiating a service specific prepayment probe review of claims for each of the following HCPCS codes:

J7682: TOBRAMYCIN, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, UNIT DOSE FORM, ADMINISTERED THROUGH DME, PER 300 MILLIGRAMS

J7686: TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG

Q4074: ILOPROST, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, UP TO 20 MICROGRAMS

Service specific prepayment probe reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Nebulizer (HCPCS J7682, J7686, Q4074) Notification of Service Specific Prepayment Probe Review.

NEBULIZERS

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

The quarterly edit effectiveness results from the Jurisdiction D DME MAC Medical Review Department from July 2015 through September 2015 are as follows:

The J7605 review currently has an overall claim potential improper payment rate of 40% and the J7626 review currently has an overall claim potential improper payment rate of 44%.

The top reasons for denial were:

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No office notes or medical records were received.
- Proof of Delivery (POD) was not received.
- Refill request was not received.

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

ORTHOTICS AND PROSTHETICS

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

The Jurisdiction D, DME MAC, Medical Review Department completed a service specific prepayment probe review of HCPCS code L4361. This review was initiated based on data analysis.

The L4361 review involved 110 claims, of which 74 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 66%.

The top reasons for denial were:

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Medical records do not support basic coverage criteria.
- Proof of Delivery (POD) was not received or is invalid.
- Detailed Written Order (DWO) is incomplete or missing elements.

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

Correct Coding – Ankle Orthoses, With or Without Joints, Prefabricated or Custom Fabricated Coding Verification Review

Joint DME MAC Publication

The Centers for Medicare & Medicaid Services HCPCS Workgroup released HCPCS codes effective January 1, 2016. Ankle orthosis codes L1902 and L1904 are revised to include reference to joints. The revised codes read:

L1902 - ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, PREFABRICATED, OFF-THE-SHELF

L1904 - ANKLE ORTHOSIS, ANKLE GAUNTLET OR SIMILAR, WITH OR WITHOUT JOINTS, CUSTOM FABRICATED

Ankle orthoses (ankle gauntlet or similar) with joints historically have been listed on DMECS as L2999 (LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED). All ankle gauntlets or similar orthoses with joints listed on DMECS as L2999 will be end dated effective June 30, 2016. All manufacturers must submit a new coding verification review application to the Pricing Data Analysis and Coding Contractor (PDAC) to reclassify those products currently listed as L2999.

The PDAC coding verification application required is the Orthotics application. This application is located on the PDAC website, https://www.dmepdac.com/review/apps_check.html.

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form located on the PDAC website: https://www.dmepdac.com.

The Ankle-Foot/Knee-Ankle-Foot Orthosis LCD will be updated with these code narrative revisions at a future date.

Correct Coding – IDEO™ and ExoSym™ Energy Storing AFO

DME MAC Joint Publication

The US Army developed the Intrepid Dynamic Exoskeletal Orthosis (IDEO™) in 2009. A civilian version, ExoSym™, became available in 2013. The brace provides energy storage and return capabilities that an injured ankle is no longer able to provide. Recent claim experience has demonstrated that HCPCS coding guidance for Medicare billing is necessary to prevent errors.

Based upon a review of the published clinical literature and publically-available descriptive information, the correct combination of HCPCS codes for billing IDEO™, ExoSym™ and similar braces are:

L1945 - ANKLE FOOT ORTHOSIS, PLASTIC, RIGID ANTERIOR TIBIAL SECTION (FLOOR REACTION), CUSTOM FABRICATED

L2755 - ADDITION TO LOWER EXTREMITY ORTHOSIS, HIGH STRENGTH, LIGHTWEIGHT MATERIAL, ALL HYBRID LAMINATION/PREPREG COMPOSITE, PER SEGMENT, FOR CUSTOM FABRICATED ORTHOSIS ONLY

Only HCPCS codes L1945 and L2755, in combination, may be used to bill for this type of brace. Use of the Not Otherwise Classified (NOC) HCPCS code L2999 is incorrect coding.

Refer to the Ankle Foot Orthosis / Knee Ankle Foot Orthosis (AFO/KAFO) Local Coverage Determination (LCD) and related Policy Article for additional information about coverage, coding and documentation.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) contractor Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

DME on Demand – Lower Limb Prostheses: Repairs

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Repairs
- RB Modifiers
- Parts
- Labor
- Resources

ORTHOTICS AND PROSTHETICS

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

DME on Demand – Lower Limb Prostheses: Replacements

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Replacement
- Documentation
- Detailed Written Order (DWO) Exception
- RA Modifier
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

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

Dear Physician Prescribing Home Oxygen – DME on Demand

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Home Oxygen Therapy
- Coverage
- Testing
- Orders
- In Summary
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

Oxygen and Oxygen Equipment (HCPCS E0431) Notification of Service Specific Prepayment Probe Review

Noridian Jurisdiction D, DME MAC, Medical Review will be initiating a service specific prepayment probe review of claims for the following HCPCS code:

> E0431: PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING

Service specific prepayment probe reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E1390. The quarterly edit effectiveness results from September 2015 through December 2015 are as follows:

The E1390 review involved 4,166 claims, of which 2,702 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 65%.

The top reasons for denial were:

- Documentation does not support the diagnosis.
- Documentation does not support that alternative treatment measures have been tried.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support that the beneficiary was seen and evaluated by the treating physician within 30 days prior to the date of the initial certification.

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

OXYGEN

Oxygen Maintenance and Service – DME on Demand

DME on Demand is a pre-recorded online presentation for DME suppliers that enable the viewer to watch and listen to the presentation at his/her convenience.

This session will include:

- Oxygen Maintenance and Service
- Months 61 and After
- Beneficiaires Entering Medicare
- Resources

Viewing Presentation

To view this presentation, go to the Event Materials and Tutorials page. All DME on Demand presentations will be listed under the Self-Paced/DME on Demand column.

If you have additional questions regarding this training session, contact us at dmeworkshops@noridian.com.

PAP DEVICES

CERT Errors – CPAPs and Accessories

The CERT Review Contractor is currently reviewing claims related to Continuous Positive Airway Pressure (CPAP) and CPAP accessories. Noridian has reviewed and listed the top Comprehensive Error Rate Testing (CERT) error comments in efforts to assist suppliers by preventing or eliminating errors, particularly for face masks and nasal application devices. The majority of the CERT denial reasons noted by Noridian relate to the physician's detailed written order. See the CERT Articles page, CERT Errors – CPAPs and Accessories, for complete information.

Physicians, Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists – Are You Ordering PAP Devices For Your Patient?

Medicare can make payment for Positive Airway Pressure (PAP) equipment and supplies when the patient's medical record shows the patient has Obstructive Sleep Apnea and meets medical documentation, test results, and health conditions as specified in the CMS Internet-Only Manual (IOM) Publication 100-03, Section 240.4.

Medical record documentation determines whether your patient can receive the PAP equipment and supplies you have prescribed and the amount of the patient's out of pocket expenses.

Medical record documentation must show an in-person or face-to-face interaction with your patient within six (6) months prior to prescribing the item, specifically to document the patient was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. For the initial evaluation, the report would commonly document pertinent information such as – signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches; the duration of those symptoms and a validated sleep hygiene inventory, but may include other details as well. Also a pertinent physical examination assessing – e.g., body mass index, neck circumference, upper airway exam and cardiopulmonary exam. It is not necessary for all of the above to be present, however it is critical that there be detailed information that identifies symptoms commonly associated with Obstructive Sleep Apnea. Multiple treating practitioners may be involved in patient care. The practitioner conducting the face-to-face visit may be different than the ordering practitioner, however the ordering practitioner must have access to evaluate the medical record.

PAP DEVICES

Your patient must have a facility-based polysomnogram or a Type II, III, or IV home sleep study after your in-person evaluation, demonstrating an Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) greater than or equal to 15 events per hour with a minimum of 30 events per hour or an AHI or RDI greater than or equal to five and less than or equal to 14 events per hour with a minimum of 10 events and documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease or history of stroke. This sleep study must take place on the same date or after the in-person or face-to-face interaction documenting signs and symptoms of OSA.

The prescription must include a detailed description of the item(s) being ordered. The order must also include the order date, patient name, your name, National Provider Identifier (NPI), signature and signature date. You must supply this signed order and the medical record documentation of your face-to-face evaluation to the supplier before they can deliver the PAP device to your patient. Please note that while PAP accessories may be provided from a dispensing order, this must be followed up with an order containing a detailed description for each item provided to your patient.

Your medical record documentation must also show a face-to-face re-evaluation with your patient between the 31st and 91st day after initiating therapy with a notation that the patient's symptoms of Obstructive Sleep Apnea are improving. Your medical record documentation must also demonstrate the patient is adhering to the therapy and that you have reviewed this adherence. Adherence to therapy is defined as use of the PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

Following this guidance will help your patients and the Medicare program by verifying that there is medical documentation to support the provision of a Positive Airway Pressure Device and allow your patient to receive the therapy needed to treat their condition. Your assistance will allow Medicare to pay claims appropriately and ensure that your patient receives the device and accessories you have prescribed.

REFILLS

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

Joint DME MAC Publication

Posted January 28, 2016

Requirements

For all DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a one- or three-month quantity at a time. See below for billing frequencies.

Documentation Requirements

A routine refill prescription is not needed. A new prescription is needed when:

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

For items that the patient obtains in person at a retail store, the signed delivery slip or copy of itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. A retrospective attestation statement by the supplier or beneficiary is not sufficient. The refill record must include:

- Beneficiary's name or authorized representative if different from the beneficiary
- A description of each item that is being requested
- Date of refill request
- For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) - The Supplier should assess the quantity of each item that the beneficiary still has remaining, to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.
- For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., Positive Airway Pressure and Respiratory Assist Device supplies) – The supplier should assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. Document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

This information must be kept on file and be available upon request.

Billing Frequencies

For refills of surgical dressings, enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anti-cancer drugs, intravenous immune globulin, and oral antiemetic drugs, only a one-month quantity of supplies may be dispensed.

For all other refills that are provided on a recurring basis suppliers may dispense no more than a three-month supply at any one time.

Miscellaneous

These requirements are not limited to DMEPOS refills for items addressed in LCDs only. All DMEPOS items that are refilled on a recurring basis are subject to these requirements.

For additional information, refer to CMS' Internet-Only Manual, Program Integrity Manual, Publication 100-08, Chapter 5, Section 5.2.8 and 5.2.9, the applicable Local Coverage Determinations and the Supplier Manual.

IVIG Demonstration: Payment Update for 2016

MLN Matters® Number: MM9254
Related Change Request (CR) #: CR 9254
Related CR Release Date: December 4, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R130DEMO
Implementation: January 4, 2016

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Q2052 (services, supplies, and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration).

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9254 to specify the payment rate for 2016 for Q2052. That 2016 payment rate is $336.05. Make sure your billing staffs are aware of the 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 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). CRs 8599 and 8724 specified the requirements for implementing this demonstration. CR 8599 specified the payment rate for the administration of IVIG under the demonstration for 2014 and CR 8599 provided for annual updates to this rate. CR8599 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R115DEMO.pdf on the CMS website.

Additional Information

The official instruction, CR 9254, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R130DEMO.pdf on the CMS website.

Payment Clarification for the Purchase of Used IRP DME when Previously Rented

MLN Matters® Number: MM9491
Related Change Request (CR) #: CR 9491
Related CR Release Date: January 29, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R1601OTN
Implementation Date: July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9491, from which this article is taken, provides clarification on the payment for the purchase of used inexpensive and routinely purchased Durable Medical Equipment (DME) in cases where there were previous rental payments.

Background

Section 1834(a), (h), and (i) of the Social Security Act (the Act) require payment on a fee schedule basis for certain Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings; and Section 1834(a)(7) and (2) provides the payment rules for capped rental DME and Inexpensive and Routinely Purchased (IRP) DME. (You can find Section 1834 of the Act at https://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet).

In determining the Medicare payment amount when the beneficiary elects to purchase previously rented IRP DME, the Medicare allowed amount should take into consideration payment made for any previous rentals.

CR9491 provides that (effective July 1, 2016) when a beneficiary elects to purchase previously rented IRP DME and the service has a UE (purchase of used equipment) modifier, the Medicare allowed amount for used purchased equipment will be calculated at the lower of the purchase fee schedule amount (UE) minus previous paid rental amounts or the actual charge for the used purchased equipment.

Specifically, in these cases, you should deduct the previous paid rental amounts or the actual charge for the used purchase equipment from the Medicare allowed amount for used purchase equipment.

Additional Information

The official instruction, CR9491 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1601OTN.pdf on the CMS website.

ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files – April 2016

MLN Matters® Number: MM9536
Related Change Request (CR) #: CR 9536
Related CR Release Date: February 4, 2016
Effective Date: April 1, 2016
Related CR Transmittal #: R3450CP
Implementation Date: April 4, 2016

Provider Types Affected

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

Provider Action Needed

Medicare will use the April 2016 quarterly Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 4, 2016, with dates of services from April 1, 2016, through June 30, 2016.

Change Request (CR) 9536 instructs MACs to implement the April 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised January 2016, October 2015, July 2015, and April 2015 files. Make sure your billing personnel are aware of these changes.

Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and 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 the "Medicare Claims Processing Manual," Chapter 4, Section 50.

REIMBURSEMENT

The following table shows how the files will be applied.

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

Additional Information

The official instruction, CR9536 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3450CP.pdf on the CMS website.

REMITTANCE ADVICE

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM9374
Related Change Request (CR) #: CR 9374
Related CR Release Date: November 25, 2015
Effective Date: April 1, 2016
Related CR Transmittal #: R3418CP
Implementation Date: April 4, 2016

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) 9374 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software. Make sure your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use it.

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 the MACs 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.

CR9374 is 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, but the deactivated code in derivative messages is allowed. MACs make necessary program changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per CR9374 or as posted on the WPC website when:

- Medicare is not primary;
- The COB claim is received after the deactivation effective date; and
- The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC website.

MACs make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a Reversal and Correction situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare Secondary Payer (MSP) claims, when forwarded to Medicare by primary payers before the deactivation date and Medicare adjudication is done after the deactivation date.

SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC website, found at http://wpc-edi.com/Reference/ on the Internet. If any new or modified code has an effective date past the implementation date specified in CR9374, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times per year and may not match the CMS systems release schedule. For this recurring CR, MACs and 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 (CR9278, with a related MLN Matters® article available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9278.pdf on the CMS website.)

In accordance with HIPAA Legislation Published in the Federal Register (45 CFR Part 162), covered entities are required to comply with established standards and code set regulations. Furthermore, the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) further defines the requirements for the 835 transaction by specifying Phase III Operating Rules, the 835 transaction (Health Care Claim Payment/Advice) and standard paper remittance advice which require the use of CARCs and RARCs.

Additional Information

The official instruction, CR9374, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3418CP.pdf on the CMS website.

TENS

TENS (HCPCS E0720 and E0730) Notification of Service Specific Prepayment Probe Review

Noridian Jurisdiction D, DME MAC, Medical Review will be initiating a service specific prepayment probe review of claims for each of the following HCPCS codes:

E0720: TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION

E0730: TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION

Service specific prepayment probe reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on a high risk problem-prone area.

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 September 2015 through December 2015 are now posted.

The A5500 review involved 3,949 claims, of which 3,354 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 84%.

The top reasons for denial were:

- Documentation of an in-person visit with the supplier at the time of delivery is incomplete.
- Documentation was not received in response to the Additional Documentation Request (ADR) Letter.
- Documentation is insufficient to show that the certifying physician has documented in the beneficiary's medical records one of the specified conditions.
- Documentation is insufficient to show that the physician has certified that the indications are met and he/she is treating the beneficiary under a comprehensive care plan for diabetes.

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

UROLOGICAL SUPPLIES

Urological Billing Reminder

Noridian wants to remind suppliers of proper billing practices in regards to Urological codes. Per the bundling table listed in Policy Article A52521, when the bundled code listed in Column I is billed, the codes in column II are not separately payable. Specifically for Urological, the reverse is also true. When the codes in Column II are provided at the same time, it must be billed with the bundled code listed in Column I.

View the complete bundling table and additional information on the Urological Supplies page.

Examples of properly billing Urological Supplies:

- When the A4310, A4338 and A4357 are provided at the same time, the A4314 must be billed.
- When the A4314 is billed, the A4310, A4338 and A4357 are not separately payable as they are included in the payment of A4314.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Urological Supplies (HCPCS A4326) Notification of Service Specific Prepayment Probe Review

Noridian Jurisdiction D, DME MAC, Medical Review will be initiating a service specific prepayment probe review of claims for the following HCPCS code:

A4326: MALE EXTERNAL CATHETER WITH INTEGRAL COLLECTION CHAMBER, ANY TYPE, EACH

Service specific prepayment probe reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on a dramatic change in frequency of use.

For complete details, see Urological Supplies (HCPCS A4326) Notification of Service Specific Prepayment Probe Review.

Ventilators (HCPCS E0466) Notification of Service Specific Prepayment Targeted Review

Noridian Jurisdiction D, DME MAC, Medical Review will be initiating a service specific prepayment targeted review of claims for the following HCPCS code:

E0466: HOME VENTILATOR, ANY TYPE, USED WITH NON-INVASIVE INTERFACE, (E.G., MASK, CHEST SHELL)

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on data analysis findings related to billing patterns.

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