DME Happenings

Jurisdiction D
Issue 52
September 2016

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FYI

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

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

Noridian Healthcare Solutions, LLC

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Alphabetical Listing

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 Provider Minute Videos for Part A and Part B Providers and DMEPOS Suppliers

The Medicare Learning Network has a series of CMS Provider Minute videos on compliance for Part A and Part B providers and Durable Medical Equipment, Prosthetics, Orthotic, and Supplies (DMEPOS) suppliers. These videos have tips to help you properly submit claims with sufficient documentation in order to receive correct payment the first time.

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.

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 am – 8 pm CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status
Supplier Contact Center	1-877-320-0390	8 am – 6 pm CT Monday-Friday
Telephone Reopenings	1-877-320-0390	8 am – 4:30 pm CT
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Website: https://med.noridianmedicare.com/web/jddme		
Fax		
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations		1-701-277-7886
Refunds to Medicare Immediate Offsets		1-701-277-7894
DME Recovery Auditor Offsets		1-701-277-7896
Medical Review Medical Documentation		1-701-277-7888
CERT Medical Documentation		1-701-277-7890
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

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

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.

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."

IVR Call-Flow Updates Coming Soon

Attention suppliers, you've asked and we've listened! As a result of supplier feedback, Noridian is updating the options of our Interactive Voice Response (IVR) System to create an even more user-friendly call flow. The IVR will soon consist of five menu options:

1. Claim Status
2. Eligibility
3. Same and Similar/Certificate of Medical Necessity (CMN) Status
4. Telephone Reopenings
5. Other

The sub-menus under Claim Status, Eligibility, and Same and Similar/CMN Status remain the same. There will now be six sub-menus within the "Other" category. These sub-menu options include:

- Financial
- Appeals Details
- Duplicate Remittance
- Power Mobility Device (PMD) Prior Authorization Request (PAR) Details
- Provider Enrollment, Chain and Ownership System (PECOS) Lookup
- Questions

Our Claim Status option has been updated as well. If a claim being researched denies for any type of "Eligibility" reason, the IVR will now automatically bring the caller to Eligibility to get that information, eliminating the need for the supplier to navigate through the IVR to the Eligibility function. This feature will make it more efficient to receive all applicable information on the beneficiary.

We are confident these changes will improve the supplier's experience when using the IVR.

IVR Navigation Changes Effective June 22, 2016

As a result of supplier feedback, we're updating the options of our Interactive Voice Response (IVR) System to create an even more user-friendly call flow. The IVR will now consist of five menu options:

1. Claim Status
2. Eligibility
3. Same and Similar/Certificate of Medical Necessity (CMN) Status
4. Telephone Reopenings
5. Other

The sub-menus under Claim Status, Eligibility, and Same and Similar/CMN Status remain the same. There will now be six sub-menus within the "Other" category. These sub-menu options include:

- Financial
- Appeals Details
- Duplicate Remittance
- Power Mobility Device (PMD) Prior Authorization Request (PAR) Details
- Provider Enrollment, Chain and Ownership System (PECOS) Lookup
- Questions

IVR Navigation Improved on Eligibility-Related Denials

Great news! Suppliers can now automatically access eligibility information from the claim status option on the Noridian JD Interactive Voice Response (IVR) System. If a claim being researched denies for any type of eligibility reason, the IVR will now automatically bring the caller to Eligibility to get that information. This eliminates the need to navigate through the IVR to the Eligibility function. This feature will make it more efficient to receive all applicable information on the beneficiary.

We are confident this change will improve the supplier's experience when using the IVR.

IVR Menu Changes

Be aware the IVR menu options have changed. Listen carefully to the new prompts before making a selection. Suppliers can select the following before entering authentication elements:

- Claim Status
- Eligibility
- Same and Similar/Certificate of Medical Necessity (CMN) Status
- Telephone Reopenings
- Other (Financial, Appeals Details, Duplicate Remittance, Power Mobility Device (PMD) Prior Authorization Request (PAR) Details, Provider Enrollment, Chain and Ownership System (PECOS) Lookup, and Questions)

View the IVR Guide [PDF] for further information.

Noridian Medicare Portal Registration Reminder – Use the IVR

Registration as a Provider Administrator in the Noridian Medicare Portal requires a recent check number and check amount on Step 6. This information should be obtained prior to registration by using the Interactive Voice Response (IVR) Financial Menu at 877-320-0390

Once on the Main Menu follow the steps below:

- Say/Select:
  - Financial Option
  - Checks
  - Last three checks

Reminders:

- No commas needed in check amount
- Check numbers do not begin with "EFT"
- Check numbers often start with the number 9

More information on Portal registration can be found on the Noridian Medicare Portal page of the Noridian website.

Portal Enhancements Implemented July 15, 2016

The Noridian Medicare Portal recently received several enhancements in response to provider/supplier recommendations received through the website satisfaction survey. Some of the changes made available July 15, 2016 improved Provider Administrator's access to oversee 25 Tax Identification Numbers improved the calendar date entry options, corrected a beneficiary name format issue, and improved the appeals submission success rate. The results for the remittance advice and DME financial inquiry were also improved.

The number one recommendation received regarding the Noridian Medicare Portal is to not require the complete Medicare Health Insurance Claim Number and/or to be more lenient with the spelling of the first and last name for eligibility inquiries. We do appreciate the position many providers and suppliers are in and the fact they may not have access to obtain a copy of the Medicare card; however, the requirement surrounding the accuracy of the eligibility data entry elements is driven by the CMS HIPAA Eligibility Transaction System (HETS) criteria.

Please share your recommendations with Noridian by completing the website satisfaction survey each time it is presented in your website navigation or portal experience.

DMD Articles Now Accessible from the Medical Director Articles Webpage

Looking for one website location where you could find all the articles written collaboratively by all DME MAC Medical Directors? Great news. The "Medical Director Articles" webpage, located within the "Policies" section of our website, is now that stop.

View the 2016 articles which may address local coverage, coding or medical review related billing and claims considerations, and may include any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy.

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

View the Medical Director Articles webpage.

Submit Redeterminations through NMP

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

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

The ability to submit redeterminations is just one of many offerings to help suppliers with their Medicare billings.

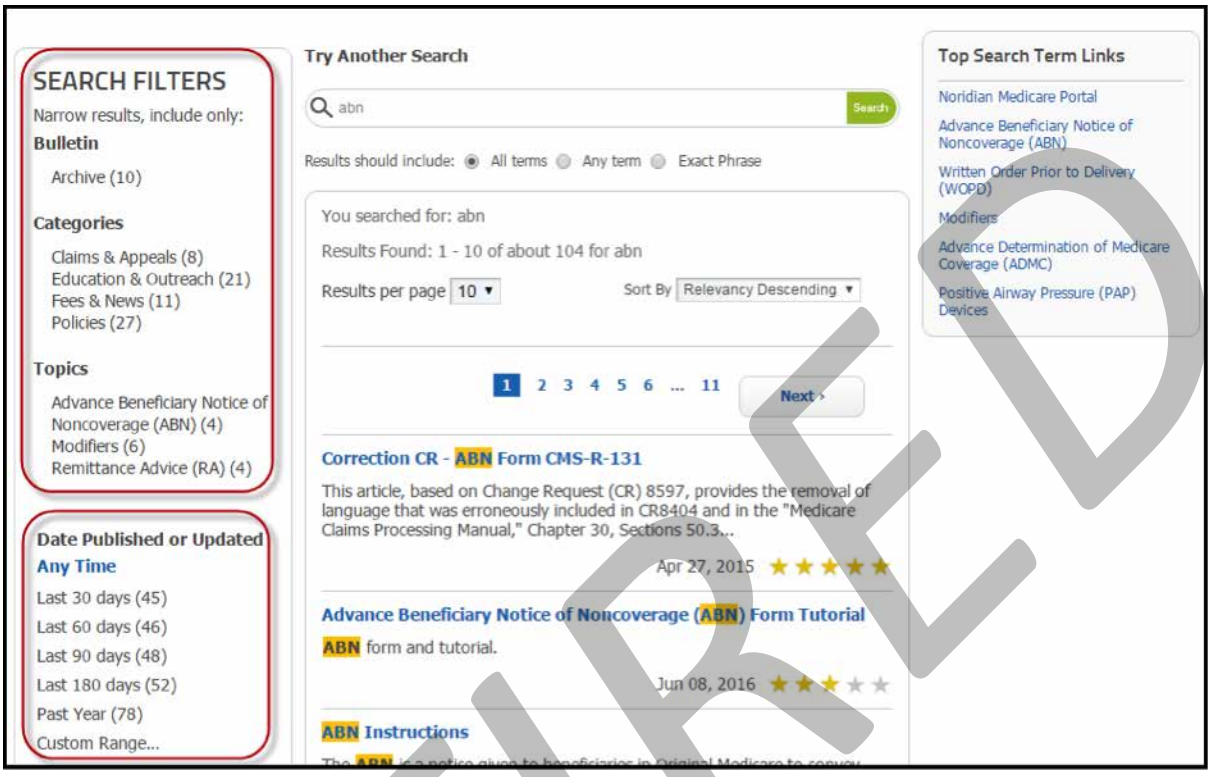
Visit our Noridian Medicare Portal today to learn more. If a supplier's company has not yet enrolled in the Noridian Medicare Portal, please share this notice with the company official so the organization can learn about all the benefits of joining. The instructions for joining the Noridian Medicare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

Website Search Results Improved

Noridian has received, listened and acted upon visitor's website search concerns. It is our goal to provide visitors with the most applicable resources within search results. Effective June 10, the search results prioritize webpages and decreases the priority of workshop presentation PDFs.

Website visitors may conduct a search using a specific term or phrase (enclosed in quotes) to locate all available resources published on that topic. The results include the webpage title, applicable source, an excerpt describing the content, a relevancy indicator based on the frequency of the searched term in the content and the content date. If a visitor chooses to refine his/her search down to a specific category for the desired content, the left-hand navigation for search result listings allows him/her to do so. Selecting a single filter under "Search Filters" will allow a visitor to see the specific search results located within that topic. Visitors may choose to refine their results by the publication date as well.

In the example below, there were 104 results for the searched term abn; but a visitor may further refine their search to view the 27 policy-specific results under the "Policies" category within "Search Filters" and again further by published date.



We hope you find these enhancements beneficial.

Implementation of Section 2 of the Patient Access and Medicare Protection Act

MLN Matters® Number: SE1614
Related Change Request (CR) #: CR9520, CR 9586
Related CR Release Date: June 7, 2016 and June 2, 2016
Effective Date: July 1, 2016 (CR9520) and October 1, 2016 (CR9586)
Related CR Transmittal #: R3535CP, R1671OTN
Implementation Date: July 5, 2016 (CR9520) and October 3, 2016 (CR9586)

Provider Types Affected

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

Provider Action Needed

This MLN Matters Special Edition Article provides important information on the implementation of Section 2 of the Patient Access and Medicare Protection Act (PAMPA), which became law on December 28, 2015. This implementation may impact the rates Medicare pays for certain DME items. Make sure your billing staffs are aware of these changes.

Background

Beginning January 1, 2016, Medicare adjusted the DME fee schedule rates to reflect information from the DMEPOS competitive bidding program as required by Section 1834(a)(1)(F)(ii) of the Social Security Act. Medicare is phasing in these adjustments during the initial 6 months of 2016 so that the fee schedule amounts in all areas will be based on a 50/50 blend of current rates and adjusted rates. Section 2 of PAMPA mandates that adjustments to the 2016 Medicare fee schedule amounts for certain DME based on information from competitive bidding programs not be applied to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs. Group 3 complex rehabilitative power wheelchair bases are currently described by codes K0848 through K0864 of the Healthcare Common Procedure Coding System (HCPCS).

Although this PAMPA change is effective January 1, 2016, Medicare cannot implement changes to the Medicare claims processing systems prior to July 5, 2016. Until then, payment for these items will be based on the adjusted fee schedule amounts. Suppliers can submit claims for these items with dates of service on or after January 1, 2016, but payment will be based on the adjusted fee schedule amounts.

On or after July 5, 2016, suppliers can adjust previously paid claims with dates of service on or after January 1, 2016, to receive the full fee schedule amount. For these items, the average adjustments made to claims processed prior to July 5, 2016 when claims were paid based on the 2016 rates during the transition period is a reduction of about 10 percent. By adjusting the claims on or after July 5, 2016, suppliers would recover that reduction.

Additional information, including the list of HCPCS codes for accessories affected by this change, as well as further instructions regarding the submission and processing of these claims, are available at https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html

Suppliers can adjust their claims after July 5, 2016. Suppliers must use the KU (DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 3) modifier for claims submitted on or after July 5, 2016, with dates of service on or after January 1, 2016, and before January 1, 2017, for any code listed in the link above describing a wheelchair accessory or seat or back cushion when furnished in connection with a Group 3 complex rehabilitative power wheelchair. The KU modifier is to be implemented as an informational modifier and must be reported to receive the unadjusted fee schedule amount. In addition, suppliers may work with their MACs to submit a list (spreadsheet) identifying the necessary criteria for the claims that meet these requirements for adjustments. Your MACs will process the adjustments that you bring to their attention.

Additional Information

You may also want to review the following related CRs:

- CR9586 (Payment Change for Group 3 Complex Rehabilitative Power Wheelchairs Accessories and Seat and Back Cushions under Section 2 of the Patient Access and Medicare Protection Act (PAMPA) for Home Health Claims) and
- CR9520 (Payment Change for Group 3 Complex Rehabilitative Power Wheelchairs Accessories and Seat and Back Cushions under Section 2 of the Patient Access and Medicare Protection Act (PAMPA) and MM9586).

Protecting Patient PHI

MLN Matters® Number: SE1616

Provider Types Affected

This MLN Matters® Article is intended for physicians, including physician group practices, that are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) using electronic systems to store Personal Health Information (PHI) of their Medicare patients.

Provider Action Needed

This MLN Matters Special Edition Article reminds physicians of the HIPAA requirement to protect the confidentiality of the PHI of their patients. Recently, the Centers for Medicare & Medicaid Services (CMS) learned of a potential security breach in which someone was offering for sale over 650,000 records of orthopedic patients. Remember that a covered entity must notify the Secretary of Health and Human Services if it discovers a breach of unsecured protected health information. See 45 C.F.R. § 164.408. Also, keep abreast of any issues that your business associates, especially those entities that provide you with hardware and/or software support for your patient electronic health records. Be sure they are required to report any actual or potential security breaches to you, especially threats that compromise patient PHI.

Background

CMS is providing this information in response to a recent report from the Cyber Health Working Group. This group recently reported the detection of an offer to sell six databases, three of which were databases that appeared to be orthopedic databases. Providers need to be extremely conscious of their systems security, especially with systems that connect to the Internet.

Additional Information

The report on the advertised sale of patient databases is available at http://hothardware.com/news/hacker-reportedly-infiltrates-three-us-healthcare-companies-offers-650000-patient-records-for-sale.

45 CFR 164.408 is available at https://www.gpo.gov/fdsys/granule/CFR-2011-title45-vol1/CFR-2011-title45-vol1-sec164-408.

Information on reporting breaches of security is available at http://www.hhs.gov/hipaa/for-professionals/breach-notification/breach-reporting/index.html.

MLN Connects® Provider eNews – June 2, 2016

MLN Connects® Provider eNews for Thursday, June 2, 2016

View this edition as a PDF

In This Edition:

MLN Connects® Events

- Physician Compare Initiative Call – Register Now
- Quality Measures and the IMPACT Act Call – Registration Now Open
- New Audio Recording and Transcript Available

Other CMS Events

- SNF Quality Reporting Program Provider Training: Reserve Your Hotel Room by June 8

Medicare Learning Network® Publications and Multimedia

- CMS Provider Minute Videos for Part A and Part B Providers and DMEPOS Suppliers

Announcements

- Medicare's "Big Data" Tools Fight and Prevent Fraud to Yield Over $1.5 Billion in Savings
- Integrated Efforts to Improve Patient Safety and Reduce Hospital Readmissions

- DMEPOS Competitive Bidding Program Round 2 Recompete and National Mail-Order Recompete: List of Contract Suppliers Available
- ICD-10 Resources: Clinical Concepts Series
- June is National Safety Month

Claims, Pricers, and Codes

- July 2016 Average Sales Price Files Available

MLN Connects® Provider eNews – June 9, 2016

MLN Connects® Provider eNews for Thursday, June 9, 2016

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News & Announcements

- Medicare Makes Enhancements to the Shared Savings Program to Strengthen Incentives for Quality Care
- TEP on Refinement of NQF #0678: Nominations due June 10
- New PEPPER for Short-term Acute Care Hospitals and June 21 Webinar
- 2016 PQRS GPRO Registration Open through June 30
- Long-Term Care Facilities: Mandatory Submission of Staffing Data via PBJ Begins July 1
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Home Health Quality of Patient Care Star Ratings TEP Summary Available

Claims, Pricers & Codes

- 2017 ICD-10-PCS Updates Available

Upcoming Events

- Physician Compare Initiative Call – June 16
- IRF Tier Comorbidity Updates: Soliciting Stakeholder Input Call – June 16
- Quality Measures and the IMPACT Act Call – July 7

Medicare Learning Network® Publications & Multimedia

- Updated Information on the IVIG Demonstration MLN Matters® Article – New
- June 2016 Catalog Available
- Medicaid Program Integrity: What Is a Prescriber's Role in Preventing the Diversion of Prescription Drugs? Fact Sheet – Revised
- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet – Revised
- Reading the Institutional Remittance Advice Booklet – Reminder
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet – Reminder

MLN Connects® Provider eNews – June 16, 2016

MLN Connects® Provider eNews for Thursday, June 16, 2016

View this edition as a PDF

News & Announcements

- CMS Proposes Rule to Improve Health Equity and Care Quality in Hospitals
- Second Round of Support and Alignment Networks Announced for Transforming Clinical Practice Initiative
- EHR Incentive Program: Hardship Exception Applications Due July 1
- CMS to Release a CBR on Immunohistochemistry and Special Stains in July
- Track and Improve Your ICD-10 Progress
- Recognizing Men's Health Month and Men's Health Week

Upcoming Events

- MIPS: CPIA Performance Category Overview Webinar – June 22
- MIPS Scoring Overview Webinar – June 24
- Quality Measures and the IMPACT Act Call – July 7
- SNF Quality Reporting Program Call – July 12

Medicare Learning Network® Publications & Multimedia

- Hospital-Acquired Conditions and Present on Admission Reporting Provision Fact Sheet – Revised
- Mass Immunizers and Roster Billing Fact Sheet – Revised
- Reading a Professional Remittance Advice Booklet – Reminder

MLN Connects® Provider eNews – June 23, 2016

MLN Connects® Provider eNews for June 23, 2016

View this edition as a PDF

News & Announcements

- Medicare Will Use Private Payor Prices to Set Payment Rates for Clinical Diagnostic Laboratory Tests Starting in 2018
- HHS Announces Major Initiative to Help Small Practices Prepare for the Quality Payment Program
- Comment on the MACRA Proposed Rule by June 27
- 2016 PQRS GPRO Registration Open through June 30
- Hospice Quality Reporting: Annual Payment Update
- Quality Payment Program: What's Available Online

Claims, Pricers & Codes

- Chronic Care Management Payment Correction for RHCs and FQHCs

Upcoming Events

- Comparative Billing Report on Diabetic Testing Supplies Webinar – June 27
- Understanding the ESRD Measures Manual Webinar – June 28
- Clinical Diagnostic Laboratory Test Payment System Final Rule Call – July 6
- Quality Measures and the IMPACT Act Call – July 7
- SNF Quality Reporting Program Call – July 12

Medicare Learning Network® Publications & Multimedia

- Video Slideshow for QRUR Webcast – New
- DMEPOS Accreditation Fact Sheet – Revised
- MREP Software Fact Sheet – Revised
- Medicare Vision Services Fact Sheet – Revised
- New Educational Web Guides Fast Fact

MLN Connects® Provider eNews – June 30, 2016

MLN Connects® Provider eNews for June 30, 2016

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News & Announcements

- ESRD and DMEPOS: Proposed Updates to CY 2017 Policies and Payment Rates
- Home Health Agencies: Proposed Payment Changes for CY 2017
- July 2016 DMEPOS Fee Schedules Available
- Moratoria Provider Services and Utilization Data Tool
- EHR Incentive Program: Hardship Exception Applications Due by July 1
- CMS to Release a CBR on Physician Assistant Use of Modifier 25 in July
- Updated Inpatient and Outpatient Data Available

Claims, Pricers & Codes

- 2017 ICD-10-CM and ICD-10-PCS Files Available

Upcoming Events

- Clinical Diagnostic Laboratory Test Payment System Final Rule Call – July 6
- DMEPOS Competitive Bidding Program Round 2 Recompete Webinars – July 7 and 12
- Quality Measures and the IMPACT Act Call – July 7
- SNF Quality Reporting Program Call – July 12
- Comparative Billing Report on Diabetic Testing Supplies Webinar – July 27

Medicare Learning Network® Publications & Multimedia

- Medicare Coverage of Diagnostic Testing for Zika Virus MLN Matters® Article – New
- Recovering Overpayments from Providers Who Share TINs MLN Matters Article – New
- Implementation of Section 2 of the PAMPA MLN Matters Article – New
- Physician Compare Call: Audio Recording and Transcript – New
- SBIRT Services Fact Sheet – Reminder
- Remittance Advice Resources and FAQs Fact Sheet – Reminder

MLN Connects® Provider eNews – July 7, 2016

MLN Connects® Provider eNews for July 7, 2016

View this edition as a PDF

News & Announcements

- HHS Announces Physician Groups Selected for an Initiative Promoting Better Cancer Care
- Open Payments Program Posts 2015 Financial Data
- Hospice CAHPS® Exemption for Size Deadline: August 10
- Help Us Improve Access to DMEPOS
- Revised CMS-855R Application: Reassignment of Medicare Benefits
- July Quarterly Provider Update Available
- Rule Gives Providers/Employers Improved Access to Information for Better Patient Care

Claims, Pricers & Codes

- Modifications to HCPCS Code Set

Upcoming Events

- SNF Quality Reporting Program Call – July 12

Medicare Learning Network® Publications & Multimedia

- Medicare Quarterly Provider Compliance Newsletter Educational Tool – New
- Subscribe to the Medicare Learning Network Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects® Provider eNews – July 14, 2016

MLN Connects® Provider eNews for July 14, 2016

View this edition as a PDF

Editor's Note:

This week's eNews includes a new section on Provider Compliance, highlighting common billing errors. Check out the first message in this series on chiropractic services and learn how to bill Medicare correctly the first time.

News & Announcements

- New Hospice Report Available July 17
- Clinical Laboratory Fee Schedule Resources
- HIPAA Administrative Simplification Enforcement and Testing Tool
- 2017 QRDA Hospital Quality Reporting Implementation Guide, Schematrons, and Sample File
- Upcoming Medicare Learning Network® Website Redesign

Provider Compliance

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

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- IRF Quality Reporting Program Provider Training – August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- LTCH Quality Reporting Program Provider Training – August 11

Medicare Learning Network Publications & Multimedia

- Medicare Billing Certificate Program for Part A Providers WBT – Revised
- Medicare Billing Certificate Programs for Part B Providers WBT – Revised
- Complying With Medicare Signature Requirements Fact Sheet – Revised
- DMEPOS Accreditation Fact Sheet – Revised
- Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet – Reminder

MLN Connects® Provider eNews – July 21, 2016

MLN Connects® Provider eNews for July 21, 2016

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Editor's Note:

Our Medicare Learning Network (MLN) website is updated to improve your access to education resources and make finding what you need easier. We hope you will take a look and share your thoughts with us. Learn more in this week's eNews.

News & Announcements

- Improved Medicare Learning Network Website
- IRF Quality Reporting Program Data Submission Deadline: August 15
- LTCH Quality Reporting Program Data Submission Deadline: August 15
- Hospice Quality Reporting: Reconsideration Period Ends Soon
- SNF Readmission Measure: Top 10 Things You Should Know
- Enhanced Administrative Simplification Website

Provider Compliance

- CMS Provider Minute: CT Scans Video

Claims, Pricers & Codes

- Billing for Nursing Visits in Home Health Shortage Areas by an RHC or FQHC

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10

Medicare Learning Network® Publications & Multimedia

- Clinical Labs Call: Audio Recording and Transcript – New
- IMPACT Act Call: Audio Recording and Transcript – New
- Medicare Podiatry Services: Information for FFS Health Care Professionals Fact Sheet – Revised
- Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians Booklet – Revised
- How to Use the National Correct Coding Initiative Tools Booklet – Revised

MLN Connects® Provider eNews – July 28, 2016

MLN Connects® Provider eNews for July 28, 2016

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News & Announcements

- Overall Hospital Quality Star Ratings: Evaluation of National Distributions
- Million Hearts® Cardiovascular Disease Risk Reduction Model
- New Payment Models and Rewards for Better Care at Lower Cost
- $42 Billion Saved in Medicare and Medicaid Primarily Through Prevention
- SNF Quarterly Reports Available through Nursing Home Compare
- SNF QRP: Requirements for the FY 2018 Reporting Year Fact Sheet Available
- EHR Incentive Programs: Submit Comments on CY 2017 Hospital OPPS and ASC Proposed Rule by September 6
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Provider Compliance

- Home Health Care: Proper Certification Required

Claims, Pricers & Codes

- July 2016 OPPS Pricer File Update

Upcoming Events

- ESRD QIP: Reviewing Your Facility's PY 2017 Performance Data Call – August 2
- Special Open Door Forum: Open Payments Notice to Inform Future Rulemaking – August 2
- Medicare Diabetes Prevention Program Webinar – August 9
- IRF Quality Reporting Program Provider Training – August 9 and 10
- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- Comparative Billing Report on IHC and Special Stains Webinar – August 10
- LTCH Quality Reporting Program Provider Training – August 11
- SNF Quality Reporting Program Provider Training – August 24
- Comparative Billing Report on Modifier 25: Physician Assistant Webinar – August 24
- IMPACT Act: Data Elements and Measure Development Call – August 31

Medicare Learning Network® Publications & Multimedia

- Protecting Patient Personal Health Information MLN Matters Article – New
- SNF Quality Reporting Program Call: Audio Recording and Transcript – New
- Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody under a Penal Authority Fact Sheet – Revised
- Electronic Mailing Lists: Keeping Health Care Professionals Informed Fact Sheet – Revised
- SNF Billing Reference Fact Sheet – Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool – Reminder
- Suite of Products & Resources for Educators & Students Educational Tool – Reminder
- Suite of Products & Resources for Inpatient Hospitals Educational Tool – Reminder
- Suite of Products & Resources for Billers & Coders Educational Tool – Reminder

MLN Connects® Provider eNews – August 4, 2016

MLN Connects® Provider eNews for August 4, 2016

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News & Announcements

- Hospital IPPS and LTCH PPS Final Rule Policy and Payment Changes for FY 2017
- SNFs: Final FY 2017 Payment and Policy Changes
- Hospice Benefit: Final FY 2017 Payment and Policy Changes
- IRFs: Final FY 2017 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2017 Payment and Policy Changes
- CMS Announces Next Phase in Largest-ever Initiative to Improve Primary Care in America
- CMS Extends, Expands Fraud-Fighting Enrollment Moratoria Efforts in Six States
- First Release of the Overall Hospital Quality Star Rating on Hospital Compare
- Home Health Agencies: New PEPPER Available
- Partial Hospitalization Programs: New PEPPER Available
- Physician Compare: 2014 Quality Data Available
- Teaching Hospital Closures: Apply for Resident Slots by October 31, 2016
- PQRS: EIDM Accounts Required to Access Feedback Reports and 2015 Annual QRURs
- Replacement of Accessories for Beneficiary-Owned CPAP Device or RAD
- Administrative Simplification Statutes and Regulations
- ICD-10 Coding Resources
- Vaccines are Not Just for Kids

Provider Compliance

- Hospital Discharge Day Management Services

Upcoming Events

- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call – August 10
- Data Collection on Resources Used in Furnishing Global Services Information Session – August 11
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Remittance Advice Information: An Overview Fact Sheet – Reminder
- Medicare Costs at a Glance: 2016 Educational Tool – Revised

MLN Connects® Provider eNews – August 11, 2016

MLN Connects® Provider eNews for August 11, 2016

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News & Announcements

- Medicare Announces Participants in Effort to Improve Access, Quality of Care in Rural Areas
- Affordable Care Act Payment Model Continues to Improve Care, Lower Costs
- ESRD QIP PY 2020 Proposed Rule: New Fact Sheet and Video
- CMS to Release a CBR on Positive Airway Pressure Devices, Respiratory Assist Devices and Accessories in August
- TEP on IMPACT Act Quality Measures: Nominations due August 21

Provider Compliance

- Preventive Services

Claims, Pricers & Codes

- ICD-10 GEMS for 2017 Available

Upcoming Events

- ESRD QIP PY 2020 Proposed Rule Call-In Session – August 16
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia

- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article – New
- IRFs: Improving Documentation Positively Impacts CERT Web-Based Training Course – New
- Physician Compare Call: Addendum – New
- RHCs HCPCS Reporting Requirement and Billing Updates MLN Matters Article – Revised
- MLN Guided Pathways Provider Specific Medicare Resources Booklet – Revised
- PECOS Technical Assistance Contact Information Fact Sheet – Revised

MLN Connects® Provider eNews – August 18, 2016

MLN Connects® Provider eNews for August 18, 2016

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News & Announcements

- CMS Updates Nursing Home Five-Star Quality Ratings
- IMPACT Act Standardized Assessment Data: Comments due August 26
- Medicare Outpatient Observation Notice: Public Comment Period Ends September 1
- Open Payments: Limited Time for Physicians to Dispute 2015 Data
- Programs of All-Inclusive Care for the Elderly
- Administrative Simplification: Adopted Standards and Operating Rules

Compliance
- Nasal Endoscopy

Claims, Pricers & Codes
- 2017 ICD-10-CM and ICD-10-PCS Code Updates
- Hospice Claim Adjustments Will Correct Routine Home Care Day Count

Upcoming Events
- IRF and LTCH Quality Reporting Program: Public Reporting Webinar – August 23
- Global Surgery Proposed Data Collection Town Hall – August 25
- IMPACT Act: Data Elements and Measure Development Call – August 31
- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15

Medicare Learning Network® Publications & Multimedia
- Medicare Part B Clinical Laboratory Fee Schedule: Guidance to Laboratories for Collecting and Reporting Data for the Private Payor Rate-Based Payment System MLN Matters Article – New
- ESRD QIP Call: Audio Recording and Transcript – New
- Health Insurance Portability and Accountability Act (HIPAA) EDI Standards Web-Based Training Course – Revised

MLN Connects® Provider eNews – August 25, 2016

MLN Connects® Provider eNews for August 25, 2016

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News & Announcements
- ICD-10: Updated Questions and Answers
- IMPACT Act Standardized Assessment Data: Comments due September 12

Provider Compliance
- Lumbar Spinal Infusion

Upcoming Events
- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15
- Comparative Billing Report on PAP/RAD and Accessories – September 21

Medicare Learning Network® Publications & Multimedia
- Next Generation Accountable Care Organization – Implementation MLN Matters® Article – New
- Medicare and Medicaid Basics Booklet – New
- PQRS Call: Audio Recording and Transcript – New
- Global Surgery Information Session: Audio Recording and Transcript – New

MLN Connects® Provider eNews – September 1, 2016

MLN Connects® Provider eNews for September 1, 2016

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News & Announcements

- PY 2015 Medicare ACO Results
- EHR Incentive Programs: Submit Comments on Proposed Rule by September 6
- TEP on IMPACT Act Quality Measures: Nominations due September 7
- ESRD QIP Preview Period for PY 2017 Extended to September 30
- New ST PEPPER Available
- ICD-10 Assessment and Maintenance Toolkit
- Are You Required to Comply with Electronic Standards?
- September is Prostate Cancer Awareness Month

Provider Compliance

- Psychiatry and Psychotherapy

Upcoming Events

- SNF Quality Reporting Program Webcast – September 14
- National Partnership to Improve Dementia Care and QAPI Call – September 15
- SNF Value-Based Purchasing Program Call – September 28

Medicare Learning Network® Publications & Multimedia

- September 2016 Catalog Available
- HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules Fact Sheet – Revised
- Guided Pathways to Medicare Resources Provider Specific Booklet – Revised
- Suite of Products & Resources for Rural Health Providers Educational Tool – Revised
- Medicare Part B Immunization Billing Fact Sheet – Reminder
- Vaccine and Vaccine Administration Payments under Medicare Part D Fact Sheet – Reminder
- Suite of Products & Resources for Compliance Officers Educational Tool – Reminder

Telephone Reopenings: Resources for Success

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

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

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

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-877-320-0390.
What are the hours for Telephone Reopenings?	Monday through Friday 8 a.m. - 6 p.m. CT Further closing information can be found at https://med.noridianmedicare.com/web/jddme/contact/holiday-schedule.
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digit of Tax ID Number (TIN) • Supplier name • Beneficiary's Health Insurance Claim Number (HICN) • Beneficiary's first and last name • Beneficiary's date of birth • Date of service (DOS) • Healthcare Common Procedure Coding System (HCPCS) code(s) in question • Corrective action to be taken **Note:** Claims with remark code MA130 can never be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

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

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

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.

Reopenings Update – Changes to Chapter 34

MLN Matters® Number: MM9639
Related Change Request (CR) #: CR 9639
Related CR Release Date: July 29, 2016
Effective Date: September 30, 2016
Related CR Transmittal #: R3568CP
Implementation Date: September 30, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9639 provides updates to Chapter 34, Section 10 of the "Medicare Claims Processing Manual" to remove outdated contractor terminology, clarify remittance advice code reference and to add hyperlinks for regulation and statutory obligations. The updates enhance and clarify operating instructions and language in accordance with regulation and statute. CR9639 includes no policy changes. Make sure that your billing staffs are aware of these updates.

Background

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (that is, filed within 1 year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within 1 year of the date of the initial determination for any reason, or within 1 to 4 years of the date of the initial determination upon a showing of good cause).

APPEALS

The main clarification in CR9639 is to note that where Medicare medical review staff request documentation from a provider/supplier for a claim, but did not receive it, and issued a denial based on no documentation, the codes used for the denial are as follows:

- **Group Code: CO** – Contractual Obligation
- **Claim Adjustment Reason Code (CARC) 50** – these are non-covered services because this is not deemed a 'medical necessity' by the payer
- **Remittance Advice Remark Code (RARC) M127** – Missing patient medical record for this service).

Additional Information

The official instruction, CR9639 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3568CP.pdf.

BILLING

JW Modifier: Drug Amount Discarded/Not Administered to any Patient – Second Revision

MLN Matters® Number: MM9603 Revised
Related Change Request (CR) #: CR 9603
Related CR Release Date: June 9, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3539CP
Implementation Date: January 3, 2017

This article was revised on June 10, 2016, to reflect the revised CR9603 issued on June 9. The CR was revised to change the effective and implementation dates. The article is revised accordingly. In the article, the CR release date, transmittal number and link to the CR were also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 9603 to alert MACs and providers of the change in policy regarding the use of the JW modifier for discarded Part B drugs and biologicals.

Effective January 1, 2017, providers are required to:

- Use the JW modifier for claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded (except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals) and
- Document the discarded drug or biological in the patient's medical record when submitting claims with unused Part B drugs or biologicals from single use vials or single use packages that are appropriately discarded

Make sure that your billing staffs are aware of these changes. Remember that the JW modifier is not used on claims for CAP drugs and biologicals.

BILLING

Background

The "Medicare Claims Processing Manual," Chapter 17, Section 40 provides policy detailing the use of the JW modifier for discarded Part B drugs and biologicals. The current policy allows MACs the discretion to determine whether to require the JW modifier for any claims with discarded drugs or biologicals, and the specific details regarding how the discarded drug or biological information should be documented.

Be aware in order to more effectively identify and monitor billing and payment for discarded drugs and biologicals, **CMS is revising this policy to require the uniform use of the JW modifier for all claims with discarded Part B drugs and biologicals.**

Additional Information

The official instruction, CR9603, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3538CP.pdf.

CEDI

Miscellaneous HCPCS Codes Require Additional Information

Common Electronic Data Interchange (CEDI) Edits

HCPCS codes with a narrative description that indicates miscellaneous, not otherwise classified (NOC), unlisted, or non-specified that is billed to the DME MAC electronically **must include a concise description of the NOC code** in the SV101-7 segment for HIPAA 5010A1 transactions. This segment is limited to 80 characters. If the claim is submitted without this information it will not pass the front-end edits and will be rejected by CEDI with the following reason codes:

- **CSCC A8:** "Acknowledgement/Rejected for relational field in error"
- **CSC 306:** Detailed description of service
- **Edit Reference:** X222.351.2400.SV101-7.020

Additional Information Required for Adjudication by the DME MAC

Items billed with any HCPCS code with a narrative description that indicates miscellaneous, NOC, unlisted, or non-specified, that is billed to the DME MAC must also include the following in loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format or on Item 19 of the paper claim form:

- Description of the item or service
- Manufacturer name
- Product name and number
- Supplier Price List (PL) amount
- HCPCS code of related item (if applicable)

Miscellaneous HCPCS codes billed without this information will be denied for incomplete and invalid information and will need to be resubmitted with the missing information included.

Miscellaneous coded products that have a specific HCPCS code must not be billed with a miscellaneous HCPCS code for that item. Inappropriate billing of miscellaneous HCPCS codes can result in a claim return/reject or denial of the HCPCS code for invalid coding.

Questions concerning HCPCS code classifications should be directed to 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 by completing the DME PDAC Contact Form located on the PDAC website at https://www.dmepdac.com/.

Refer to the applicable Local Coverage Determinations (LCDs) and related Policy Articles for additional information on requirements for miscellaneous HCPCS codes.

CERT Documentation

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

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

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

The secure fax number for submitting documentation to the CERT Documentation Contractor is (240) 568-6222.

Mail all requested documentation to:

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

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

Suppliers may call the CERT Documentation Contractor at (301) 957-2380 with questions regarding specific documentation to submit.

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

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

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

CERT MAC Improper Payment Rates for 2014 and 2015

Noridian Healthcare Solutions is pleased to announce that the CMS recently published the Comprehensive Error Rate Testing (CERT) 2014 and 2015 improper payment rates by Medicare Administrative Contractor (MAC) Jurisdictions. Visit: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/MedicareFFSJurisdictionErrorRateContributionData.html to view interactive maps and learn more about: improper payments; error rate scoring; and corrective actions.

The national projected error rates have been provided below.

2014

Claim Type	Projected Improper Payment	Improper Payment Rate
Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)	$5.1	53.1%
Part A (Total)	$29.6	11.4%
Part A (Excluding IPPS)	$19.2	13.1%
Part A (Hospital IPPS)	$10.4	9.2%
Part B	$11.0	12.1%

2015

Claim Type	Projected Improper Payment	Improper Payment Rate
DMEPOS	$3.2	39.9%
Part A (Total)	$28.7	11.0%
Part A (Excluding IPPS)	$21.7	14.7%
Part A (Hospital IPPS)	$7.0	6.2%
Part B	$11.5	12.7%

Note that the figures in the above tables have been adjusted for A to B rebilling and some totals may not appear to properly average due to rounding. Dollars displayed are in billions.

As the CMS stated in their July 21, 2016 publication, *Medicare Fee For Service (FFS) Jurisdiction Error Rate Contribution Data*, "Provider compliance is fundamental to reducing improper payment rates. Both the CMS and MACs are engaged in a continuing process to identify and execute new and promising practices to improve provider compliance."

Noridian Healthcare Solutions reminds providers and suppliers that they have a direct impact on the improper payment rates. The leading error category, as published in the *Medicare Fee-for-Service 2015 Improper Payments Report*, is Insufficient Documentation. Providers are encouraged to review intake processes and Local Coverage Determinations to ensure they have proper documentation on file for the items being billed.

To receive additional information on the educational products and services Noridian Healthcare Solutions offers, please contact the appropriate email addresses below.

- **Part A:** CERTPartAQuestion@noridian.com
- **Part B:** CERTQuestion@noridian.com
- **JD DME:** JDDMECERT@noridian.com
- **JA DME:** JADMECERT@noridian.com

New Non-Physician Specialty Code for Dentist – Revised

MLN Matters® Number: MM9355 Revised
Related Change Request (CR) #: CR 9355
Related CR Release Date: June 22, 2016
Effective Date: July 1, 2016 for MCS; January 1, 2017 for MACs
Related CR Transmittal #: R3547CP and R269FM
Implementation Date: July 5, 2016 for MCS, January 3, 2017 for MACs

This article was revised on June 24, 2016, due to an updated Change Request (CR). The update changed the effective date to January 1, 2017, but the effective date for MCS remains July 1, 2016, the full implementation date to January 3, 2017, but the implementation date remains July 5, 2016 for MCS. All other information remains the same.

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/R3547CP.pdf. The second transmittal updates the "Medicare Financial Management Manual" and it is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R269FM.pdf.

Coding Revisions to NCDs – Revised

MLN Matters® Number: MM9631 Revised
Related Change Request (CR) #: CR 9631
Effective Date: October 1, 2016 - unless noted differently in CR9631
Related CR Release Date: June 3, 2016
Related CR Transmittal #: R1672OTN
Implementation Date: October 3, 2016

This article was revised on June 6, 2016, to reflect the revised CR9631 issued on June 3, 2016. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

CR9631 is the 8th maintenance update of International Classification of Diseases, Tenth Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). The majority of the NCDs included are a result of feedback received from previous ICD-10 NCD CRs, specifically CR7818, CR8109, CR8197, CR8691, CR9087, CR9252, and CR9540, while others are the result of revisions required to other NCD-related CRs released separately. Review MLN Matters® Articles MM7818, MM8109, MM8197, MM8691, MM9087, MM9252, and MM9540 for information pertaining to these CR's.

Background

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

No policy-related changes are included with these updates. Any policy-related changes to NCDs continue to be implemented via the current, long-standing NCD process. Updated NCD coding spreadsheets related to CR9631 are available at https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR9631.zip.

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

To be specific, CR9631 makes adjustments to the following NCDs:

- **NCD 20.4 –** Implantable Automatic Defibrillators
- **NCD 20.7 –** Percutaneous Transluminal Angioplasty (PTA)
- **NCD 20.9 –** Artificial Hearts
- **NCD 20.29 –** Hyperbaric Oxygen Therapy
- **NCD 50.3 –** Cochlear Implants
- **NCD 110.18 –** Aprepitant
- **NCD 210.3 –** Colorectal Cancer Screening
- **NCD 220.4 –** Mammography
- **NCD 230.9 –** Cryosurgery of Prostate
- **NCD 260.9 –** Heart Transplants

- **NCD 210.4 –** Smoking/Tobacco-Use Cessation Counseling
- **NCD 210.4.1 –** Counseling to Prevent Tobacco Use

Additional Information

The official instruction, CR 9631, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1672OTN.pdf.

Correction of Remark Code Information

MLN Matters® Number: MM9641
Related Change Request (CR) #: CR 9641
Related CR Release Date: July 15, 2016
Effective Date: October 17, 2016
Related CR Transmittal #: R3560CP
Implementation Date: October 17, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9641 updates the "Medicare Claims Processing Manual," Chapter 30, to make corrections to Remittance Advice Codes and general punctuation and grammar corrections. All Remittance Advice messaging must follow a prescribed set of rules. Specifically, Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) may only be used in specified combinations laid out by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), the designated Standards Development Organization (SDO). The CARC and RARC code sets are available via the Washington Publishing Company (WPC) at http://www.wpc-edi.com/Reference.

Additional Information

The official instruction, CR9641, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3560CP.pdf.

HPTC – October 2016 Code Set Update

MLN Matters® Number: MM9659
Related Change Request (CR) #: CR 9659
Related CR Release Date: August 26, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3597CP
Implementation Date: January 3, 2017, except some MACs may implement on October 1, 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 and Hospice MACs and Durable Medical Equipment MACs, for services provided to Medicare beneficiaries.

What You Need to Know

CR9659 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and to update their internal HPTC tables and/or reference file. MACs that have the capability to do so will implement the October 2016 HPTC set as early as October 1, 2016, for claims received on or after October 1, 2016. All MACs will implement the HPTC set by January 3, 2017.

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.
4. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid.

CR9659 implements the NUCC HPTC code set that is effective on October 1, 2016, and instructs MACs to obtain the most recent HPTC set at http://www.wpc-edi.com/codes and use it to update their internal HPTC tables and/or reference files.

When reviewing the HPTC 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, CR 9659 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3597CP.pdf.

HCPCS Codes for SNF CB – 2017 Annual Update

MLN Matters® Number: MM9735
Related Change Request (CR) #: CR 9735
Related CR Release Date: August 26, 2017
Effective Date: January 1, 2017
Related CR Transmittal #: R3603CP
Implementation Date: January 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

Provider Action Needed

If you provide services to Medicare beneficiaries in a Part A covered SNF stay, information in Change Request (CR) 9735 could impact your payments.

CR9735 provides the 2017 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for SNF Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems. By the first week in December 2016, the new code files for Part B processing, and the new Excel and PDF files for Part A processing, will be available at http://www.cms.gov/SNFConsolidatedBilling and will become effective on January 1, 2017.

The provider community should read the "General Explanation of the Major Categories" PDF file located at the bottom of each year's MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background

The Common Working File (CWF) currently has edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. These edits allow only those services that are excluded from consolidated billing to be separately paid.

Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow MACs to make appropriate payments in accordance with policy for SNF CB, found in the Chapter 6, Section 20.6 (Part A) and Section 110.4.1 (Part B) of the "Medicare Claims Processing Manual," available for download at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf.

Additional Information

The official instruction, CR9735, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3603CP.pdf.

Correct Coding – HCPCS Coding Recommendations from Non-Medicare Sources

DME MAC Joint Publication

Correct Healthcare Common Procedure Coding System (HCPCS) code selection for a product is an essential element for claims payment. Use of the appropriate HCPCS code assures that accurate processing can be accomplished resulting in a proper claim determination and reimbursement. Conversely, incorrect coding may result in improper payment necessitating recoupment and possible false claim actions. Thus, it is important that all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers take steps to ensure that claims are correctly coded.

Background

The HCPCS is a standardized set of codes used for billing items and services to all payers, including Medicare and Medicaid. The HCPCS is divided into two principal subsystems, referred to as level I and level II. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services, dental services, and procedures furnished by physicians and other health care professionals.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and DMEPOS when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.

In October of 2003, the Secretary of Health and Human Services (HHS) delegated authority under the HIPAA legislation to CMS to maintain and distribute HCPCS Level II Codes. As stated in 42 CFR 414.40 (a), CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. To accomplish the task of maintaining the Level II HCPCS system, CMS established a workgroup comprised of representatives of the major components of CMS, CMS contractors, as well as other participants from pertinent Federal agencies, and representatives of state Medicaid agencies, the private insurance sector and the Department of Veteran's Affairs.

Each payer separately develops their own coverage criteria, coding guidelines, and fees for HCPCS Level II codes.

Coding Guidelines for Medicare

For Medicare claims, only CMS and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have authority to establish HCPCS Level II Coding Guidelines. The CMS Internet Only Manual (IOM), Publication 100-08, Program Integrity Manual (PIM), Chapter 3, Section 3.3.B and Section 3.6.2.4 instruct, in relevant part:

> [A]n item/service is correctly coded when it meets all the coding guidelines listed in … CMS HCPCS policy or guideline requirements, LCDs, or MAC articles.

The DME MACs and the Pricing, Data Analysis, and Coding (PDAC) contractor are responsible for assigning individual DMEPOS products to HCPCS code categories for billing Medicare. Manufacturers and other entities do not have similar authority to assign their own code determinations to specific products. Often these unofficial and unauthorized coding assignments are described as "recommendations". DMEPOS suppliers are cautioned that such recommendations have no official status and, in the event of a claim review, may result in an incorrect coding claim denial. In addition, these unofficial coding recommendations are not helpful in defense of an incorrect coding claim denial during the appeals process.

When a product has been formally reviewed by the DME MACs or PDAC, the manufacturer is provided with a letter informing them of the correct coding to be used for Medicare billing purposes. We encourage DMEPOS suppliers only to accept coding information from manufacturers and others when the product has been officially coded and a correct coding letter has been issued or the specific product is listed on DMECS.

The DME MACs publish coding guidelines in LCD related Policy Articles and in correct coding bulletins. The information in these publications is considered the authoritative coding instructions for Medicare billing purposes as described in PIM Chapter 3.

PDAC maintains product listings for many HCPCS codes on the website. Select, "Durable Medical Equipment Coding System (DMECS)" to search for HCPCS codes and associated product lists. Not every HCPCS code has a product classification list; but reviewed products are added to the listings for each code as coding determinations are completed. For Medicare claim purposes, this product classification listing is accepted as evidence of correct coding.

Correct Coding of Claims

Each supplier is ultimately responsible for the HCPCS code(s) they select to bill for the items provided. Resources like code determinations letters and DMECS are useful but many products have not been reviewed. For these un-reviewed products, each supplier must use their best judgment in selecting HCPCS codes for billing. Here are some tips that will help:

- Check the PDAC Product Classification Lists on DMECS. Although not every HCPCS code has an associated product list, many of the most commonly used codes do.
- Check the DME MAC publications for coding bulletins and coding guidelines related to products and HCPCS codes for specific information on the item of interest.
- Refer to the "long" code narrative. All codes have short and long descriptors. The long descriptor often provides more detail regarding the requirements for the code. Select the code with the descriptor that most closely describes the product.
- Most code narratives are written broadly to be all-inclusive. You may not find a specific code that perfectly matches a product. Use the code that most closely describes the item rather than a NOC (not otherwise classified) or miscellaneous code.
- Local Coverage Determination related Policy Articles often have additional information in the Coding Guidelines section. Coding guidelines provide additional information on the characteristics of products that meet a specific HCPCS code.
- Remember that price and fees are NOT part of correct coding. Selecting a code based upon the fee schedule almost always results in an incorrect coding determination. HCPCS codes describe the product not the price.

- Check with the PDAC. The PDAC Contact Center can provide information that will assist you in code selection. This assistance, however, is NOT considered a formal product review. The advice provided is not an official code determination. Items are not added to the DMECS Product Classification List based on a query to the PDAC Contact Center.
- Request that manufacturers submit their products for coding. Although some HCPCS codes require mandatory product review in order to use the code, for most codes product review is voluntary. Many manufacturers are responsive to their customer' requests for verified HCPCS coding.

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 and Coverage – Oral Suspensions used in the Treatment of Oral Mucosal Injuries

Joint DME MAC Publication

In recent years, several products have come to market for use by beneficiaries with oral mucosal injuries. These products, Mugard Mucoadhesive (AMAG Pharmaceuticals, Inc.), Gelclair (DARA BioSciences Inc.), and similar products claim to adhere to the injured mucosal surface providing protection. These oral suspensions are used in the treatment of oral mucosal injuries caused by a variety of underlying illnesses and treatments. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) Medical Directors have evaluated these products for coverage.

Medicare is a defined benefit program. In order for any item to be eligible for payment, the item must first be eligible for inclusion into one of the statutorily established benefit categories. The Medicare Surgical Dressings Benefit provides the definition of covered dressings that are eligible for dressing reimbursement. CMS Internet Only Manual (IOM), Publication 100-02, *Benefit Policy Manual*, Chapter 15, Section 100 says, in relevant part:

> Surgical dressings are **limited to primary and secondary dressings** required for the treatment of a wound…
>
> Primary dressings are therapeutic or protective coverings applied directly to **wounds or lesions either on the skin or caused by an opening to the skin**. Secondary dressing materials that serve a therapeutic or protective function and that are needed to secure a primary dressing are also covered. (Emphasis added)

This benefit limits coverage to wounds of the skin. Treatments used for injuries to the oral mucosa are not eligible for coverage under this benefit as oral mucosa is not skin. It is a different tissue type and thus is excluded from this benefit.

Although these products may serve a beneficial purpose in the treatment of oral mucosal injuries, there is no coverage available under the Surgical Dressings benefit for these items. There is no other benefit category under which Medicare coverage might be possible. Claims submitted to the DME MACs for these products must use HCPCS code:

- **A9270** – NON-COVERED ITEM OR SERVICE

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.

Correct Coding – Cantilever Type Armrest

DME MAC Joint Publication

A cantilever or flip up armrest is a non-detachable armrest that pivots to move the armrest away from the patient in a fashion analogous to a swing-away armrest. There is no specific HCPCS code for this item. These types of movable armrests are included in the Basic Equipment Package for power wheelchairs and power seating systems. To bill this type of armrest separately at initial issue, the correct HCPCS code is:

- **A9900** – MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE

To bill this type of armrest as a repair to a covered wheelchair or seating system, the correct HCPCS code is:

- **K0108** – WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED *

In this repair billing scenario code K0108 includes all parts necessary to replace the armrest. As a repair, K0108 must be used in combination with the appropriate repair modifier (RB – REPLACEMENT OF A PART OF DME FURNISHED AS PART OF A REPAIR).

If the entire wheelchair or seating system is being replaced, there is no separate payment for a cantilever armrest, as described above. Use HCPCS code A9900 for separate billing of the armrest in this scenario.

Note: When a NOC (not otherwise classified/specified) code is billed the claim must be accompanied by:

- Description of item or service
- Product name
- Manufacturer name

Refer to the Wheelchair Options/Accessories LCD and related Policy Article for additional information about coverage, documentation, and coding.

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 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

Correct Coding – Eclipse™ Vaginal Insert system (Pelvalon, Inc.)

Joint DME MAC Article

The Eclipse™ Vaginal Insert system (Pelvalon, Inc.) is an inflatable vaginal insert designed to exert pressure on the rectal vault to treat fecal incontinence. FDA approval for marketing under this indication was granted on February 12, 2015. According to the manufacturer, the Eclipse™ system consists of a vaginal insert and a pressure-regulated pump. The insert, consisting of a silicone-covered stainless steel base and a posteriorly directed balloon, is placed in the vaginal vault and inflated. The balloon is deflated via the pump when the user needs to have a bowel movement.

The insert must first be fitted in the physician's office. This procedure is billed under a CPT code that is all-inclusive. Services rendered in a physician office and billed under a CPT code are not within the jurisdiction of the DME MACs. Items provided as part of that service are considered incident to the service and are not separately billable to the DME MACs.

The DME MACs have determined that the Eclipse™ Vaginal Insert system meets the requirements of the Prosthetic Devices benefit (Social Security Act §1861(s)(9)). To meet this benefit, the device must replace all or part of a non-functioning body member. There is currently no HCPCS code assigned to the Eclipse™ system. The DME MACs have determined that this item must be coded as:

- **A4335** – INCONTINENCE SUPPLY, MISCELLANEOUS

Suppliers are reminded that items billed with a miscellaneous HCPCS code require the following documentation to be submitted with the claim:

- Description of the item or service
- Manufacturer name
- Product name and number

Miscellaneous HCPCS codes billed without this information will be rejected for missing documentation and will need to be resubmitted with the missing information.

This information will be added to the Bowel Management Devices Local Coverage Determination and related Policy Article in an upcoming revision.

Questions concerning HCPCS code classifications should be directed to the Pricing, Data Analysis and Coding (PDAC) contractor - 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 www.dmepdac.com/dmecs.

Correct Coding – JW Modifier Use – Revised – Effective for Claims with Dates of Service On or After January 1, 2017

Joint DME MAC Publication

Revised June 16, 2016 to reflect change in Effective Date
Revised May 19, 2016
Posted September 16, 2010

The Centers for Medicare & Medicaid Services (CMS) recently issued updated guidance on the billing of drug wastage to REQUIRE use of the JW modifier (DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT). For the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), the JW modifier only applies to the following Local Coverage Determinations (LCDs):

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

These LCDs will be updated to include the JW modifier requirements. Required use of the JW modifier is effective for claims with dates of service (DOS) on or after January 1, 2017.

The Medicare Claims Processing Manual (Internet-only Manual 100-04), Chapter 17, Section 40 contains information on the use of the JW modifier for discarded drugs and biologicals. The Medicare program provides payment for the amount of a single use vial or other single use package of drug or biological discarded, in addition to the dose administered, up to the amount of the drug or biological. There are two scenarios that can occur:

Scenario 1

When the HCPCS code Unit of Service (UOS) is less than the drug quantity contained in the single use vial or single dose package, the following applies:

- The quantity administered is billed on one claim line without the JW modifier; and,
- The quantity discarded is billed on a separate claim line with the JW modifier.

In this scenario, the JW modifier must be billed on a separate line to provide payment for the amount of discarded drug or biological. For example:

- A single use vial is labeled to contain 100 mg of a drug.
- The drug's HCPCS code UOS is 1 UOS = 1 mg.
- 95 mg of the 100 mg in the vial are administered to the beneficiary.
- 5 mg remaining in the vial are discarded.

- The 95 mg dose is billed on one claim line as 95 UOS.
- The discarded 5 mg is billed as 5 UOS on a separate claim line with the JW modifier.
- Both claim line items would be processed for payment.

Scenario 2

When the HCPCS code UOS is equal to or greater than the total of the actual dose and the amount discarded, use of the JW modifier is not permitted. If the quantity of drug administered is less that a full UOS, the billed UOS is rounded to the appropriate UOS. For example:

- A single use vial is labeled to contain 100 mg of a drug.
- The drug's HCPCS code UOS is 1 UOS = 100 mg.
- 70 mg of the 100 mg in the vial are administered to the beneficiary.
- 30 mg remaining in the vial are discarded.
- The 70 mg dose is billed correctly by rounding up to one UOS (representing the entire 100 mg vial) on a single line item.
- The single line item of 1 UOS would be processed for payment of the combined total 100 mg of administered and discarded drug.
- The discarded 30 mg must not be billed as another 1 UOS on a separate line item with the JW modifier. Billing an additional 1 UOS for the discarded drug with the JW modifier is incorrect billing and will result in an overpayment.

Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Claims for drugs billed to Medicare must use drug dosage formulations and/or unit dose sizes that minimize wastage. Providers and suppliers are expected to use drugs or biologicals most efficiently, in a clinically appropriate manner. Only when the most efficient combination of dosage forms are used and there is drug remaining may a supplier bill the discarded amount using the JW modifier on the claim line for the UOS not administered to the patient. Because of the HCPCS code descriptors and the associated UOS for DMEPOS items, the DME MACs expect rare use of the JW modifier on claims.

The JW modifier is used in conjunction with other modifiers listed in the applicable LCDs. For example, suppliers must add a JW modifier to codes for nebulizer drugs, in conjunction with the KX modifier, only if all of the criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section of the Nebulizer LCD have been met.

Correct Coding – Martin Bionics Socket-less Socket – Revised

Effective June 1, 2016

DME MAC Joint Publication

Originally published March 10, 2016

This article revises the Correct Coding article published March 10, 2016, to provide specific HCPCS codes for Medicare billing. HCPCS code L5999 (LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED), which is currently used for billing purposes, is being replaced with specific L-codes. The revised coding requirements are effective for claims with dates of service on or after June 1, 2016.

The Socket-less Socket™ (Martin Bionics) is an open frame above-knee socket design. This product uses a combination of fixed and floating struts attached to a base and connected by adjustable straps to form the structure of the socket. The product is supplied as a prefabricated kit and fit directly to the beneficiary.

Existing HCPCS L-codes used for above-knee lower limb prosthesis sockets describe items which enclose the residual limb to provide the stability, proprioception, and suspension necessary for the effective use of an artificial limb. Although the Socket-less Socket™ is different in design from traditional sockets described by the existing L-codes, we have determined that this product is an effective alternative, and that existing HCPCS codes appropriately describe the product. The correct combination of codes to bill Medicare for this item are:

Base code:

If this product is included as part of a complete prosthesis, the base socket is included as part of the prosthesis base code. Chose the appropriate base code depending upon the type provided.

L5321 - SOCKET ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE.

L5590 - PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION ISCHIAL LEVEL SOCKET, NON-ALIGNABLE SYSTEM, PYLON NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL

The addition codes discussed below (L5631, L5649, L5950) and choice of suspension must be included on the same claim for the complete prosthesis i.e., the claim that includes one of the above codes.

If this product is provided as a replacement to an existing socket, in addition to the add-on codes below (L5631, L5649, L5950) and choice of suspension, for the base code, use:

L5701 - REPLACEMENT, SOCKET, ABOVE KNEE/KNEE DISARTICULATION, INCLUDING ATTACHMENT PLATE, MOLDED TO PATIENT MODEL.

Do not use L5321 or L5590 for billing a replacement socket for an existing prosthesis.

Addition codes:

Use these codes on all claims in addition to the base code:

L5631 - ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, ACRYLIC SOCKET.

L5649 - ADDITION TO LOWER EXTREMITY, ISCHIAL CONTAINMENT/NARROW M-L SOCKET.

L5950 - ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, ULTRALIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL).

The combination of base and addition codes listed above include all the features and functions of the Socket-less Socket™. HCPCS code L5999 must not be used to bill for features or functions included in the socket. Use of L5999 in this manner will be rejected as incorrect coding (unbundling).

Suspension:

HCPCS add-on L-codes used to describe the type of suspension incorporated into the socket may be added to the claim. Use of more than one type of suspension is considered incorrect billing (same/similar item).

Other Additions:

HCPCS codes describing features that may not be necessary on all sockets may only be used when the feature is provided for the individual beneficiary. Some examples of features that are not automatically included in every socket or for all beneficiaries are (not all-inclusive):

L5651 - ADDITION TO LOWER EXTREMITY, ABOVE KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME

L5920 - ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM

NOTE: The Socket-less Socket™ includes an option to use a combination of "flower distal cup technology with special NASA-based mesh fabric" as a functional alternative to a flexible inner socket. This combination of materials is not considered to be a flexible inner socket and must not be coded using L5651. L5999 must not be used for these items as payment for these materials is considered included in the payment for the base code. Separate claims for these materials will be denied as incorrect coding (unbundling).

The prosthetic record must include specific, detailed information justifying the need for each additional feature.

Test sockets (L5624 - ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE) are not necessary for the production of this socket design. Claims for L5624 in conjunction with this socket design are considered incorrect billing.

Refer to the Lower Limb Prosthesis Local Coverage Determination and related Policy Article for additional information on coverage, coding and documentation for artificial limbs.

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 – Braces Constructed Primarily of Elastic or Other Fabric Materials

DME MAC Joint Publication

Revised: July 28, 2016

Originally posted: January 1, 2009

The 2009 PDAC Article "Elastic Garments – Noncovered" is revised to provide a more comprehensive discussion of statutory benefit category requirements and HCPCS coding guidelines applicable to these items.

Benefit Category

All orthoses are covered under the Medicare Braces Benefit (Social Security Act §1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Items that are not sufficiently rigid to be capable of providing the necessary immobilization or support to the body part for which it is designed do not meet the statutory definition of the Braces Benefit. Therefore, claims for these items will be denied as noncovered, no benefit category.

The following spinal orthoses HCPCS codes contain both elastic and inelastic items in the same HCPCS code. The applicable codes are:

- L0450 - TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, UPPER THORACIC REGION, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
- L0454 - TLSO, FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
- L0455 - TLSO FLEXIBLE, PROVIDES TRUNK SUPPORT, EXTENDS FROM SACROCOCCYGEAL JUNCTION TO ABOVE T-9 VERTEBRA, RESTRICTS GROSS TRUNK MOTION IN THE SAGITTAL PLANE, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS WITH RIGID STAYS OR PANEL(S), INCLUDES SHOULDER STRAPS AND CLOSURES, PREFABRICATED, OFF-THE-SHELF
- L0621 - SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

- L0625 - LUMBAR ORTHOSIS, FLEXIBLE, PROVIDES LUMBAR SUPPORT, POSTERIOR EXTENDS FROM L-1 TO BELOW L-5 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, SHOULDER STRAPS, STAYS, PREFABRICATED, OFF-THE-SHELF
- L0628 - LUMBAR-SACRAL ORTHOSIS, FLEXIBLE, PROVIDES LUMBO-SACRAL SUPPORT, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISKS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE STAYS, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

There are special HCPCS modifier coding instructions that must be used to separate items made of elastic and inelastic materials. (see below)

Coding Guidelines

For the spinal garment codes listed above (L0450, L0454, L0455, L0621, L0625, L0628), effective for claims with dates of service on or after April 1, 2009:

- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®) (not all-inclusive)) must add the GY modifier to the code.
- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®) (not all-inclusive)) that contain stays and/or panels must add the GY modifier to the code.
- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed must add the CG modifier to the code.
- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed and that have stays and/or panels capable of providing the required immobilization or support to the body part for which it is designed must add the CG modifier to the code.
- Items that are not capable of providing the necessary immobilization or support to the body part for which it is designed (regardless of materials) must add the GY modifier to the code.

If the CG or GY modifier is not used with one of the preceding HCPCS codes, the claim will be rejected as incorrect coding.

For items where the HCPCS code specifies "elastic" use the code that is applicable.

For items where the HCPCS code does not specify elastic (other than the spinal codes listed above), the following guidelines apply:

- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®) (not all-inclusive)) must be coded as A4466 (GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH).
- Items that are primarily constructed of elastic or other stretchable materials (e.g. support items made of material such as neoprene or spandex (elastane, Lycra®]) (not all-inclusive)) that contain stays and/or panels must be coded as A4466 (GARMENT, BELT, SLEEVE OR OTHER COVERING, ELASTIC OR SIMILAR STRETCHABLE MATERIAL, ANY TYPE, EACH).
- Items that are primarily constructed of inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed must be coded using the applicable specific HCPCS code for the type of product. A NOC (Not Otherwise Classified) or miscellaneous HCPCS code must not be used. Refer to the long code narrative and any relevant coding guideline for the criteria applicable for each HCPCS code.

CODING

- Items that are primarily of constructed inelastic material (e.g., canvas, cotton or nylon (not all-inclusive)) capable of providing the necessary immobilization or support to the body part for which it is designed that have stays and/or panels capable of providing the required immobilization or support to the body part for which it is designed must be coded using the applicable specific HCPCS code for the type of product. A NOC (Not Otherwise Classified) or miscellaneous HCPCS code must not be used. Refer to the long code narrative and any relevant coding guideline for the criteria applicable for each HCPCS code.
- Items that are not capable of providing the necessary immobilization or support to the body part for which it is designed (regardless of materials) must be coded using A9270 (NONCOVERED ITEM OR SERVICE).

This information will be incorporated into a future revision of the Ankle-Foot/Knee-Ankle-Foot Orthoses (AFO/KAFO), Knee Orthoses (KO), and Spinal Orthoses (LSO/TLSO) LCDs and related Policy Articles.

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 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

COMPETITIVE BIDDING

DMEPOS CBP: Additional Instructions for the Implementation of Round 2 Recompete of the DMEPOS CBP Program and National Mail Order Recompete – Third Revision

MLN Matters® Number: MM9579 Revised
Related Change Request (CR) #: CR 9579
Related CR Release Date: August 17, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3593CP
Implementation Date: October 3, 2016

This article was revised on August 17, 2016, due to a revised Change Request (CR). That CR changed a business requirement (BR) for payments. The BR is included in this article as a note on the last page. The transmittal number, CR release date and link to the transmittal also changed. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued CR 9579 to provide instructions detailing changes to the DMEPOS Competitive Bidding Program (CBP) regarding the clarification of the RB modifier for Medicare payment for the repair of parts furnished in Competitive Bidding Areas (CBAs) and clarification of grandfathering instructions for rentals of accessories and supplies.

Background

The purpose of CR9579 is to provide instructions for implementing the following clarifications to the DMEPOS CBP program.

Clarification of Medicare Payment for Repair Parts Furnished in Competitive Bidding Areas

Under the Medicare DMEPOS CBP, repairs of beneficiary-owned items may be performed by any Medicare-enrolled supplier. Repairs to certain, medically necessary beneficiary-owned equipment are covered when necessary to make the equipment serviceable. Labor to repair equipment is not subject to competitive bidding and is paid according to Medicare's general payment rules.

CR8181 (see related article MM8181) implemented claims billing and processing instructions for wheelchair accessories furnished for use with non-competitively bid wheelchair base units for beneficiaries who permanently reside in competitive bid areas. This instruction implemented use of the KY modifier in certain instances. This instruction clarifies how payment is made for repair parts furnished in competitive bidding areas.

In accordance with 42 CFR 414.408(k)(1)(iii), payments for repair parts that are described by HCPCS codes for competitive bidding items and are furnished in CBAs are made based on the single payment amount established for the HCPCS code. Payment for such repair parts that are furnished for use in repairing base equipment that are not competitive bidding items in the area is made in accordance with 42 CFR 414.408(k)(1)(ii), which provides that payment for the part is made based on the MAC's consideration of the item under 42 CFR 414.210(e). When making payment determinations for parts described by HCPCS codes for competitive bidding items furnished for use in repairing base equipment that are not competitive bidding items, MACs have discretion to use the single payment amounts for the item in establishing the Medicare allowed amount for the repair part.

The regulations at 414.210(e) also provide that payment for repair parts is made on a lump sum purchase basis. **Therefore, effective October 1, 2016**, all repair part claims billed with the RB modifier, whether within or outside a CBA, whether described by a HCPCS code that is a competitive bidding item or not, and whether described by a code for miscellaneous (not otherwise classified or specified) items or not, shall be paid on a lump sum purchase basis.

Additionally, CMS has become aware that wheelchair claims are being submitted with the following modifier combinations: the RB and KY; RB and KE; and RB and RR modifiers. If the claim is for a repair part, these three following combinations are not valid, and the claim will be returned as unprocessable.

Clarification of Grandfathering instructions

Under the Medicare DMEPOS CBP, a beneficiary who obtains competitive bidding items in a designated CBA must obtain these items from a contract supplier, unless an exception applies. One exception is that a beneficiary may continue to obtain a DME rental item(s) from a non-contract supplier if the beneficiary was receiving the rented item(s) from the non-contract supplier when the CBP took effect in the CBA. Such non-contract supplier would be considered a "grandfathered supplier" with respect to such rented item and such beneficiary for the remainder of the period during which rental payments are made (for example, for the remainder of the 13-month period of continuous use for a capped rental item). An additional exception is that a beneficiary, who continues to obtain a rented, grandfathered competitive bidding item from a non-contract, grandfathered supplier, may also obtain certain covered accessories or supplies furnished for use with such rented "grandfathered" equipment from the same non-contract, grandfathered supplier for the remainder of the period during which rental payments are made (for example, for the remainder of the 13-month period of continuous use for a capped rental item).

For rented, grandfathered equipment in the capped rental payment class (for example, a Continuous Positive Airway Pressure (CPAP) device or manual wheelchair), after the rental payment cap for the grandfathered equipment and after the rental payment cap on the accessory (when applicable, such as, elevating leg rests) is reached, the beneficiary must obtain covered accessories and supplies (for example, CPAP masks) from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies once the rental payment cap on the grandfathered equipment is reached, with the exception of completing the rental period for accessories when the first rental month began during the rental period for the grandfathered equipment (for example, the addition of elevating leg rests during the third rental month for a grandfathered manual wheelchair). For rented, grandfathered equipment in the inexpensive or routinely purchased payment class, after the total payments for the rented, grandfathered equipment (such as a folding walker) reach the purchase fee schedule amount for the grandfathered equipment, and after the rental payment cap on the accessory is reached (when applicable), the beneficiary must obtain covered accessories (for example. seat attachment) and supplies from a contract supplier. The supplier of the grandfathered equipment is no longer permitted to furnish the covered accessories and supplies once the rental payment cap on the equipment is reached, with the exception of completing the rental period for accessories when the first rental month began during the rental period for the grandfathered equipment.

In all cases, payment for covered accessories and supplies used in conjunction with a grandfathered item is based on the single payment amount calculated for the item for the CBA in which the beneficiary maintains a permanent residence.

In summary, Medicare payment may be made to a non-contract, grandfathered supplier for furnishing certain covered accessories or supplies furnished for use with rented, grandfathered equipment, provided the non-contract supplier is also furnishing the rented equipment on a grandfathered basis. Once rental payments for the grandfathered equipment have ended, Medicare payment will no longer be made to a non-contract, grandfathered supplier for furnishing accessories or supplies with the exception of completing the rental period for rented accessories.

The following instruction was added to CR 9579 on August 17, 2016: Payments will be allowed at the fee schedule amount for accessory rental items (modifier RR) submitted with modifier KY by non-contract suppliers that are furnished for use with non-bid wheelchair bases. This applies to any wheelchair accessory rental item that has the Business Rule G on the CBIC HCPCS file.

Additional Information

The official instruction, CR9579 issued to your MAC regarding this change is available at http://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/R3593CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-LearningNetwork-MLN/MLNMattersArticles/index.html under - How Does It Work.

You may review MM 8181, "Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) National Competitive Bidding (NCB): Using the "KY" Modifier to Bill for Accessories for Non-NCB Wheelchair Base Units" (Transmittal 1184, February 8, 2013) at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNMattersArticles/downloads/MM8181.pdf.

You can find additional information on the DMEPOS CBP at https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/DMEPOSCompetitiveBid/index.html.

More information is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2recompete.nsf/DocsCat/Home. This site includes information on all rounds of the CBP, including product categories single payment amounts for the Round 1 Re-compete, Round 2, and the national mail-order program for diabetic testing supplies; and the ZIP codes of areas included in the CBP.

DMEPOS CBP – Quarterly Update October 2016

MLN Matters® Number: MM9701
Related Change Request (CR) #: CR 9701
Related CR Release Date: July 1, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3554CP
Implementation October 3, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9701 provides the October 2016 quarterly update for the Medicare DMEPOS fee schedule. The instructions include information, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The Centers for Medicare & Medicaid Services (CMS) issued CR9701 to provide the DMEPOS Competitive Bidding Program (CBP) October 2016 quarterly update.

COMPETITIVE BIDDING

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

Background

The DMEPOS CBP was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services. Under the program, Medicare conducts a competition among suppliers who operate in a particular Competitive Bidding Area. Suppliers must submit a bid for selected products. 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, CR9701 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3554CP.pdf.

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

COVERAGE

IVIG Demonstration – Updated Information

MLN Matters® Number: SE1610

Provider Types Affected

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

As mentioned in MLN Matters Article SE1424, suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider Action Needed

In this article, the Centers for Medicare & Medicaid Services (CMS) informs providers that a new Medicare contractor, Noridian Healthcare Solutions, LLC, will replace NHIC as the implementation support contractor for the IVIG demonstration as of July 1, 2016. This article also reminds suppliers of the 2016 payment rate for demonstration service code Q2052. The 2016 payment rate is $336.05. As of June 2016, Medicare is continuing to accept applications from beneficiaries on a rolling basis. This will continue as long as the funding or enrollment limitations are not reached or until the demonstration ends, whichever occurs sooner. As of June 24th, applications should no longer be submitted to NHIC. The last date to submit an application for coverage prior to September 30, 2017 (when the demonstration is scheduled to end) is August 15, 2017. Make sure your staff is aware of this information.

Background

In MLN Matters Article SE1424, CMS provides a complete overview of the IVIG demonstration. Part of the overview includes a discussion of how beneficiaries need to submit an application in order to participate in the demonstration. As of June 24, 2016, such applications must be submitted to Noridian Healthcare Solutions, LLC.

The enrollment application and the application completion guide will be available at https://med.noridianmedicare.com/web/ivig or through the IVIG Call Center at (844)-625-6284. You can also sign up to receive IVIG Demonstration ListServe updates from the new Implementation Support Contractor.

As of June 24, 2016, completed applications may be submitted by fax or mail to Noridian.

- Applications may be mailed to:

  Noridian Healthcare Solutions, LLC
  IVIG Demo
  PO Box 6788
  Fargo, ND 58108-6788

- For overnight mailings:

  Noridian Healthcare Solutions, LLC
  IVIG Demo
  900 42nd Street South
  Fargo, ND 58103

- Applications may be faxed to:

  Fax: 701-277-2428

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

Medicare Coverage of Diagnostic Testing for Zika Virus

MLN Matters® Number: SE1615

Provider Types Affected

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

Provider Action Needed

This MLN Matters Special Edition Article informs the public that Medicare covers Zika virus testing under Medicare Part B as long as the clinical diagnostic laboratory test is reasonable and necessary for the diagnosis or treatment of a person's illness or injury. This article reminds laboratories furnishing Zika virus tests to contact their MACs for guidance on the appropriate billing codes to use on claims for Zika virus testing. Furthermore, laboratories should provide resources and cost information as may be requested by the MACs in order for the MACs to establish appropriate payment amounts for the tests.

Background

On February 1, 2016, the World Health Organization (WHO) declared the Zika virus a Public Health Emergency of International Concern (PHEIC)[1]. According to the Centers for Disease Control and Prevention (CDC), the Zika virus disease is a nationally notifiable condition that has caused outbreaks in many countries and territories. The virus is primarily spread through the bite of an infected Aedes species mosquito, although other modes of transmission include mother-to-child transmission, blood transfusion and sexual transmission. [2] Currently there are a few diagnostic tests that can determine the presence of the virus. These tests are available through the CDC and CDC-approved state health laboratories. A small number of tests have been issued an Emergency Use Authorization by the Food and Drug Administration (FDA) and may be available through commercial laboratories.

Medicare Part B pays for clinical diagnostic laboratory tests that are reasonable and necessary for the diagnosis or treatment of a person's illness or injury. Presently there are no specific HCPCS codes for testing of the Zika virus; however, laboratories should contact their local MACs for guidance on the appropriate billing codes to use on claims for Zika virus testing. Furthermore, laboratories should provide resources and cost information as may be requested by the MACs in order for the MACs to establish appropriate payment amounts for the tests.

Additional Information

More information is available in the "Clinical Laboratory Fee Schedule: Payment System Series" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Clinical-Laboratory-Fee-Schedule-Fact-Sheet-ICN006818.pdf and in the "CY 2016 Clinical Laboratory Fee Schedule; 16CLAB" at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html.

[1] United States. Centers for Disease Control and Prevention. (2016) About Zika Virus. Retrieved from http://www.cdc.gov/zika/about/index.htm

[2] United States. Centers for Disease Control and Prevention. (2016) Zika Virus. Retrieved from http://www.cdc.gov/zika/about/index.html.

IVIG Demonstration – Implementation – Revised

MLN Matters® Number: SE1424 Revised

This article was revised on June 2, 2016, to make suppliers aware that a new contractor is administering this demonstration. See article SE1610 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1610.pdf for more information.

Provider Types Affected

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

Suppliers do not need to apply to participate in the demonstration as long as they meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of demonstration covered services.

Provider Action Needed

In this article, the Centers for Medicare & Medicaid Services (CMS) alerts providers to a three year demonstration 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). CMS has designed the IVIG demonstration to pay a bundled payment for items and services needed for the in-home administration of intravenous immune globulin for the treatment of PIDD. The demonstration will begin paying for services as of October 1, 2014, and will continue for three years, as long as funding remains available.

Background

Depending on the circumstances, traditional fee-for-service (FFS) Medicare covers some, or all, components of home infusion services. By special statutory provision, Medicare Part B covers IVIG for persons with PIDD who wish to receive the drug at home. Medicare does not separately pay for any services or supplies to administer the drug if the person is not homebound, and is otherwise receiving services under a Medicare Home Health episode of care. As a result, many beneficiaries have chosen to receive the drug at their doctor's office, in an outpatient hospital setting, or to self-administer the drug subcutaneously. Beneficiaries may also alternate between settings or drug formulations, if necessary, to accommodate travel or other personal situations.

IVIG Demonstration

The "Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012" authorized the demonstration under Part B of Title XVIII of the Social Security Act. The demonstration is limited to no more than 4,000 beneficiaries, and the $45 million budget covers benefit costs, as well as administrative expenses for implementation and evaluation. Participation is voluntary and may be terminated by the beneficiary at any time.

Under this demonstration, Medicare will issue under Part B a bundled payment for all items and services that are necessary to administer IVIG in the home to enrolled beneficiaries who are not otherwise homebound and receiving home health care benefits. In processing all services and supplies needed for the administration of IVIG, CMS is not making any changes to existing coverage determinations to receive the IVIG drug in the home or for services and supplies that are otherwise not covered under the traditional FFS Medicare Part B benefit.

The demonstration only applies to situations where the beneficiary requires IVIG for the treatment of PIDD, or is currently receiving subcutaneous immune globulin to treat PIDD and wishes to switch to IVIG. This demonstration does not apply if the immune globulin is intended to be administered subcutaneously. Only those beneficiaries with PIDD who are eligible to receive IVIG under the current Medicare benefit (have Part B, and have traditional FFS Medicare) will be eligible to enroll in the demonstration and have the services paid under the new demonstration.

This demonstration will not change how subcutaneous administration of immune globulin (SCIG) is covered and paid for under the traditional Medicare FFS program. Also, nothing in this demonstration will impact how IVIG is paid by Medicare for beneficiaries who are covered under a home health episode of care.

Beneficiaries participating in the demonstration shall not be restricted in any way from receiving Medicare covered IVIG, and non-demonstration Medicare covered related services from different providers at different times should they so choose. For example, a beneficiary receiving services under the demonstration at home may choose to switch and receive them at a doctor's office or outpatient department at any time. The beneficiary may switch back to receiving services under the demonstration as long as they are otherwise still eligible, and funding remains available.

Beneficiaries under hospice shall not be excluded from this demonstration, and their demonstration claims shall be processed in the same manner as other Medicare (non-demonstration) claims for hospice patients.

Beneficiaries covered under a home health episode of care may apply to participate in the demonstration but will not be eligible to have services paid for under the demonstration until after the home health episode of care has ended. Similarly, beneficiaries who are participating in the demonstration and subsequently become eligible to receive services under a home health episode of care will not be eligible to have services paid for under the demonstration for the period of time they are covered under such episodes.

Providers/suppliers billing for the services and supplies covered under the demonstration must meet all Medicare as well as other national, state, and local standards and regulations applicable to the provision of services related to home infusion of IVIG.

Beneficiary Eligibility

In order to pay for the new demonstration covered services, the following requirements must be met:

1. The beneficiary must be enrolled in the demonstration on the eligibility file provided by NHIC, Corp., the implementation support contractor (as of July 1, 2016, Noridian Healthcare Solutions, LLC is the support contractor);
2. The beneficiary must be eligible to have the IVIG drug paid for at home (has a diagnosis of PIDD) under the traditional Medicare benefit;
3. The beneficiary must be enrolled in Medicare Part B and not be enrolled in a Medicare Advantage plan (i.e. have traditional FFS Medicare coverage);
4. The beneficiary must not be covered on the date of service in a home health episode (In such circumstances, the services are covered under the home health episode payment.)
5. The place of service must be the beneficiary's home or a setting that is "home like".

Billing Details

A new "Q" code has been established for services, supplies, and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration:

- **Q2052 – (Long Description) –** Services, supplies, and accessories used in the home under Medicare Intravenous immune globulin (IVIG) demonstration.
- **Q2052 – (Short Description) –** IVIG demo, services/supplies.

The code is for use with the IVIG demo only and the jurisdiction for this code is DME MAC.

The new demonstration service code (Q2052) must be billed as a separate claim line on the same claim for the IVIG drug itself.

Specialty pharmacies will bill for the IVIG drug itself when intended for home administration by beneficiaries who are not homebound and not covered under a home health benefit episode. For those beneficiaries participating in the demonstration, specialty pharmacies shall bill for the demonstration covered services on the same claim as the drug itself. Claims for the demonstration bundled service (Q2052) billed in the absence of the "J" code for the IVIG drug will not be payable. The new demonstration covered services will be paid as a bundle and will be subject to coinsurance and deductible in the same manner as other Part B services.

For 2014, the nationwide Medicare allowable for Q2052 will be $300 each time the IVIG is administered. (The 2016 payment rate for Q2052 is $336.05.) While this is expected to be approximately monthly, it can be more or less frequent depending upon a patient's medical need.

As with all DMEPOS claims, specialty pharmacies will bill these claims to the appropriate DME MAC jurisdiction based on the beneficiary's state.

The following "J" codes (as updated by CR 8724) represent immune globulin drugs that are administered intravenously and payable in 2014 under Medicare Part B for services rendered in the home (or home-like setting) for beneficiaries with PIDD: Privigen, (J1459), Bivigam (J1556), Gammaplex (J1557), Gamunex (J1561), Immune Globulin Not Otherwise Specified (J1566 and J1599), Octagam (J1568), Gammagard liquid (J1569), and Flebogamma (J1572). Immune globulin drugs covered under Medicare Part B for administration in the home for patients with PIDD are subject to change; coverage of any drugs under the demonstration shall not differ from drugs that are eligible for payment under Part B for beneficiaries not enrolled in the demonstration.

If the claim for IVIG is not otherwise payable under Medicare Part B, the Q2052 claim line is not payable under the demonstration. The claim for Q2052 must have the same place of service code on the claim line as the IVIG (J code) for which it is applicable. In cases where the drug is mailed or delivered to the patient prior to administration, the date of service for the administration of the drug (the "Q2052" claim line) may be no more than 30 calendar days after the date of service on the drug claim line.

If multiple administrations of IVIG are submitted on a single claim, each date of service for the administration of the drug (Q2052) must be on a separate claim line. If these requirements are not met, the claim will not be processed and Medicare will return a Group Code of CO (Contractual Obligation) a Remittance Advice Remarks Code (RARC) of M51 (Missing/incomplete/invalid procedure code(s)) and a Claim Adjustment Remarks Code (CARC) of B15 (This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated).

If a claim is submitted with the HCPCS Q2052 code and the beneficiary is not enrolled in the demonstration on the date of service, the claim will be denied with a RARC of M138 (Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.), a CARC of 96 (Non-covered charge(s)), and a Group Code of CO.

Coverage of demonstration services shall be subject to the usual coordination of benefit process and the usual Medicare Secondary Payer process as well.

Questions and Answers Relating to Supplier Eligibility

Question: Is the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) Supplier required to be certified to bill the A/B MACs in order to provide the nursing component of the Q2052 – Services, Supplies and Accessories Used in the Home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration?

Answer: No. The DMEPOS supplier must currently be able to bill the DME MACs (enrolled and current with the National Supplier Clearinghouse) and meet all regulatory and statutory requirements. If a state requires licensure to furnish certain items or services, a DMEPOS supplier: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by State law. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other federal procurement or non-procurement programs.

Question: Can the supplier/pharmacy contract or subcontract nursing services for the administration of the IVIG to bill the Q2052 - Services, Supplies and Accessories Used in the Home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration?

Answer: Yes. If a state requires licensure to furnish certain items or services, a supplier/pharmacy: Must be licensed to provide the item or service; and may contract with a licensed individual or other entity to provide the licensed services unless expressly prohibited by State law.

A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other federal procurement or non-procurement programs.

How Beneficiaries can apply for the IVIG Demonstration

To participate in this demonstration the beneficiary must complete and submit an application form. All applications must be signed by the beneficiary as well as his or her physician. **Submission of an application does not guarantee that a beneficiary will be accepted to participate in the demonstration.**

CMS has contracted with NHIC, Corp., DME MAC Jurisdiction A, (NHIC is being replaced by Noridian as of July 1, 2016) to help administer the demonstration. NHIC (Noridian, effective July 1, 2016) will review all applications for eligibility and will create and upload an enrollment file to be used by CMS' claims processing systems.

CMS conducted an initial enrollment period from 8/08/2014 – 9/12/2014.

Since the number of beneficiaries and funds available to implement this demonstration are limited, not all beneficiaries who are eligible may be accepted if more eligible beneficiaries apply than can be served with the funds available. If the number of eligible beneficiaries that apply during the initial enrollment period is below the statutory limits, then additional applications will continue to be accepted after the 9/12/2014 deadline on a rolling basis until enrollment and/or funding limits are reached. As of June 2016, Medicare is continuing to accept applications from beneficiaries on a rolling basis. This will continue as long as the funding or enrollment limitations are not reached or until the demonstration ends, whichever occurs sooner. The last date to submit an application for coverage prior to September 30, 2017 (when the demonstration is scheduled to end) is August 15, 2017.

Until June 24, 2016, the enrollment application and the application completion guide are available at: http://www.medicarenhic.com or through the IVIG Demo Hot Line at: (844)-625-6284.

As of June 24, 2016, the enrollment application and the application completion guide will be available at http://med.noridianmedicare.com/web/ivig.

COVERAGE

Until June 23, 2016, completed applications may be submitted by fax or mail to NHIC, Corp. at the following address:

- Applications may be mailed to:

  NHIC, Corp.
  IVIG Demo
  P.O. Box 9140
  Hingham, MA. 02043-9140

- For overnight mailings:

  NHIC, Corp
  IVIG Demo
  75 William Terry Dr.
  Hingham, MA. 02043

- Applications may be faxed to:

  Fax 781-741-3533

As of June 24, 2016, completed applications may be submitted by fax or mail to Noridian.

- Applications may be mailed to:

  Noridian Healthcare Solutions, LLC
  IVIG Demo
  PO Box 6788
  Fargo, ND 58108-6788

- For overnight mailings:

  Noridian Healthcare Solutions, LLC
  IVIG Demo
  900 42nd Street South
  Fargo, ND 58103

- Applications may be faxed to:

  Fax 701-277-2428

Additional Information

If you have any questions, please contact your DME MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

EDUCATIONAL

JD DME Ask the Contractor Teleconference Meeting Minutes – June 9, 2016

Noridian DME Outreach and Education has posted the minutes from the JD Ask the Contractor (ACT) Teleconference meeting held June 9, 2016. For complete information, see the ACT webpage.

Timely Reporting of Provider Enrollment Information Changes

MLN Matters® Number: SE1617

Provider Types Affected

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

Provider Action Needed

Failure to comply with the requirements to report changes in your Medicare enrollment information could result in the revocation of your Medicare billing privileges. This article does not establish any new or revised policy, but serves as a reminder to comply with existing policy. MLN Matters® Article SE1617 reinforces the importance of the timely reporting of changes in your Medicare enrollment information. Comply with the reporting requirements for changes in your enrollment information and avoid disruption of your Medicare claims payments.

Background

In accordance with 42 Code of Federal Regulations (CFR) Section 424.516(d), all physicians, non-physician practitioners (for example, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutrition professionals) and physician and non-physician practitioner organizations must report the following changes in their enrollment information to your MAC via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) or the CMS 855 paper enrollment application within 30 days of the change:

- A change in ownership
- An adverse legal action, or
- A change in practice location.

You must report all other changes to your MAC within 90 days of the change.

If you are a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), you must report any changes in information supplied on the enrollment application within 30 days of the change to the National Supplier Clearinghouse (NSC) (42 CFR §424.57(c)(2)).

Independent Diagnostic Testing Facilities must report changes in ownership, location, general supervision, and adverse legal actions to your MAC either online, or via the appropriate CMS-855 form, within 30 calendar days of the change. You must report all other changes to your enrollment information within 90 days of the change (42 CFR §410.33(g)(2).

All providers and suppliers not previously identified must report any changes of ownership, including a change in an authorized or delegated official, within 30 days; and all other informational changes within 90 days (42 CFR §424.516(e)).

It is very important that you comply with these reporting requirements. Failure to do so could result in the revocation of your Medicare billing privileges.

External Infusion Pumps (HCPCS J1817) 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 J1817. This review was initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

The J1817 review involved 108 claims, of which 99 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 93%.

The top reasons for denial were:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.
- Documentation does not support administration of continuous subcutaneous insulin for the treatment of diabetes mellitus.
- Detailed Written Order (DWO) is incomplete or missing elements.

Based on the results of this review, Noridian will begin a service specific targeted review on HCPCS codes J1817. For complete details, see External Infusion Pumps (HCPCS J1817) Results of Service Specific Prepayment Probe Review.

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

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

The E0781 review involved 87 claims, of which 47 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 37%.

The E0784 review involved 76 claims, of which 48 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 61%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support a covered indication.
- Detailed Written Order (DWO) was not received.
- Proof of Delivery (POD) was not received.

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

FORMS

Certificates of Medical Necessity and DME Information Forms

Joint DME MAC Publication

Recently the DME MACs have received inquiries about expired Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs). These forms must be periodically reauthorized. The Final Notice extending the use of all CMNs and DIFs was published in the *Federal Register* on May 11, 2016, and all forms have been extended through 2019.

GLUCOSE MONITORS

Glucose Monitors (HCPCS A4253) 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 each of the following HCPCS code:

A4253: BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS

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 internal data anda high Comprehensive Error Rate Testing (CERT) error rate.

For complete details, see Glucose Monitors (HCPCS A4253) Notification of Service Specific Prepayment Targeted Review.

HOSPITAL BEDS

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

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

The E0250 review involved 113 claims, of which 53 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 51%.

The top reasons for denial were:

- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is incomplete or missing elements.
- Documentation does not contain a valid date stamp or similar.

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

LCD and Policy Article Revisions Summary for July 7, 2016

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 Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics). Please review the entire LCD and related PA for complete information.

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
LCD
Revision Effective Date: 07/01/2016

HCPCS CODES:
Added: HCPCS code Q9981

DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation language to add New order requirements, and Correct coding instructions; revised Proof of delivery instructions (Effective 04/28/16)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: HCPCS Q9981 for billing instructions

Policy Article
Revision Effective Date: 07/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Covered 3-drug combination regimen with Q9981

CODING GUIDELINES:
Added: HCPCS Q9981 for billing Rolapitant effective on or after 07/01/2016
Added: End date for HCPCS Q0181
Added: HCPCS Q9981 to coding instructions

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, suppliers must review the LCD and/or Policy Article.

LCD Revisions Summary for August 4, 2016

Outlined below are the principal changes to a DME MAC Local Coverage Determination (LCD) that has been revised and posted. The policy included is Knee Orthoses. Please review the entire LCD for complete information.

Knee Orthoses LCD
Revision Effective Date: 07/01/2016

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Replaced: ICD-10 Code M21.869 with Q68.2 in Group 5 – Effective 10/01/2015
DOCUMENTATION REQUIREMENTS:
Revised: Standard language – Start Date instructions – Effective 04/28/2016

Note: The information contained in this article is only a summary of revisions to the LCD. For complete information you must review the LCD.

LCD and Policy Article Revisions Summary for August 11, 2016

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Bowel Management Devices, Nebulizers and Oral Anti-Cancer Drugs. Please review the entire LCD and related PA for complete information.

Bowel Management Devices
LCD
Revision Effective Date 07/01/2016

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Vaginal inserts and accessories information (Effective date 02/12/2015)

HCPCS MODIFIERS:

Deleted: GA, GZ, GY modifiers

DOCUMENTATION REQUIREMENTS:

Revised: Standard documentation language to Orders, revise Proof of delivery instructions, and add Correct coding instructions (Effective date 04/28/2016)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Deleted: GA, GZ, GY modifiers section

Policy Article
Revision Effective Date: 07/01/2016

CODING GUIDELINES:

Added: Coding guideline definition of vaginal insert (Effective date

02/12/2015)

Nebulizers
LCD
Revision Effective Date: 07/01/2016

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard documentation language - ACA requirements – Effective 04/28/16

Added: A7007 and A7017 related accessories table for E0572

Added: Denial verbiage for JW Modifier when coverage criteria not met - Effective 01/01/17

HCPCS MODIFIERS:

Added: JW Modifier – Effective January 1, 2017

DOCUMENTATION REQUIREMENTS:

Revised: Standard documentation language for orders and ACA requirements, added New order requirements, and Correct coding instructions; revised Refill requirements to change "should" to "must", revised Proof of delivery instructions – Effective 04/28/16

Added: JW Modifier instructions – Effective January 1, 2017

Policy Article
Revision Effective Date: 07/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Standard documentation language-adding Statutory Prescription (Order) Requirements, revising ACA requirements – Effective 04/28/16

Revised: Dispensing fee date example from 04/20 to 04/10

Oral Anticancer Drugs
LCD
Revision Effective Date: 07/01/2016

COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation language for Refill Requirements (Effective 04/28/16)

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation language in orders, added New order requirements;
revised language in Refill documentation, Proof of delivery instructions, and added Correct coding instructions (Effective 04/28/16)

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Updated: “should” to “must” for electronic claim narrative requirement

Policy Article
Revision Effective Date: 10/01/2015:

Covered ICD-10 Codes:

Added: C7B.00, C7B.01, C7B.02, C7B.03, C7B.04 and C7B.09 to Groups 2 and 8 (Effective 10/01/2015)

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 LCDs and/or Policy Articles.

LCD and Policy Article Revisions Summary for August 18, 2016

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Automatic External Defibrillators, Heating Pads and Heat Lamps, High Frequency Chest Wall Oscillations Devices. Please review the entire LCD and related PA for complete information.

Automatic External Defibrillators
LCD
Revision Effective Date: 07/01/2016

DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language for orders, and Proof of delivery instructions, added New order requirements, and Correct coding instructions; (Effective 04/28/2016)

Policy Article
Revision Effective Date: 07/01/2016

Updated: Title to remove effective date

Heating Pads and Heat Lamps
LCD
Revision Effective Date: 07/01/2016

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation language - ACA order requirements – Effective 04/28/16
DOCUMENTATION REQUIREMENTS:
Revised: Standard documentation language for orders, ACA order requirements, added New order requirements, and Correct coding instructions; revised Proof of delivery instructions – Effective 04/28/16

Policy Article
Revision Effective Date: 07/01/2016

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised Standard Language to add Statutory Prescription (Order) Requirements, revised Face to Face and ACA requirements - Effective 04/28/2016

High Frequency Chest Wall Oscillation Devices
LCD
Revision Effective Date: 07/01/2016

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation language - ACA order requirements – Effective 04/28/16
DOCUMENTATION REQUIREMENTS:
Revised: Standard documentation language for orders, ACA requirements, and Proof of delivery instructions; added New order requirements, and Correct coding instructions – Effective 04/28/16

Policy Article
Revision Effective Date: 10/01/2015:

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised Standard Language to add Statutory prescription (order) requirements, revised Face to Face and ACA requirements - Effective 04/28/2016

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 LCDs and/or Policy Articles.

LCD AND POLICY ARTICLES

LCD and Policy Article Revisions Summary for August 25, 2016

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication "LCD and Policy Article Revisions Summary for August 25, 2016" is now available on our (Noridian) website.

View the complete LCD and Policy Article Revisions Summary for August 25, 2016 webpage.

NEGATIVE PRESSURE WOUND THERAPY

Negative Pressure Wound Therapy Pumps (HCPCS E2402) Quarterly Results of Service Specific Prepayment Review

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

The E2402 review involved 254 claims, of which 151 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 53%.

The top reasons for denial were:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support evaluation of and provision for the beneficiary's adequate nutritional status.
- Proof of Delivery (POD) is incomplete or missing elements.
- Documentation does not support the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments.

For complete details, see Negative Pressure Wound Therapy Pumps (HCPCS E2402) Quarterly Results of Service Specific Prepayment Review.

ORTHOTICS AND PROSTHETICS

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

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

The L1832 review involved 181 claims, of which 181 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

The L1843 review involved 125 claims, of which 124 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.

Top Denial Reasons

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

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

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code L1833. The quarterly edit effectiveness results from December 2015 through March 2016 are as follows:

The L1833 review involved 627 claims, of which 607 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 96%.

The top reasons for denial were:

- Documentation does not support knee instability or that the beneficiary is ambulatory.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Invalid or missing diagnosis code.
- Proof of Delivery (POD) is invalid.

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

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

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

The L1833 review involved 511 claims, of which 462 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 92%.

The top reasons for denial are:

- Documentation does not support knee instability.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is incomplete or missing elements.
- Internal Classification of Diseases (ICD) 10 code was missing or invalid.

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

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

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

The L4361 review involved 165 claims, of which 115 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 70%.

The top reasons for denial are:

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

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

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

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

The L0631 review involved 172 claims, of which 171 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.

The L0637 review involved 160 claims, of which 152 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 99%.

The top reasons for denial are:

- Documentation does not support that modifications were made for the custom fitted item.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) is incomplete or missing elements.
- Documentation does not support coverage criteria.

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

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

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

The L0648 review involved 306 claims, of which 227 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 74%.

The L0650 review involved 520 claims, of which 429 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 82%.

The top reasons for denial were:

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

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

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

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

The L1960 review involved 176 claims, of which 129 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 73%.

The L1970 review involved 300 claims, of which 237 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 78%.

The L4360 review involved 425 claims, of which 414 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

The top reasons for denial are:

- Documentation does not support that modifications were made for the custom fitted item.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support medical necessity of custom fabricated rather than prefabricated orthosis.
- Proof of Delivery (POD) was not received.

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

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

Recovering Overpayments from Providers Who Share Tax Identification Numbers

MLN Matters® Number: SE1612

Provider Types Affected

This MLN Matters® Article is intended for providers of services and suppliers who share the same Tax Identification Number (TIN) even though they may have different National Provider Identifiers or other billing numbers used to bill Medicare.

OVERPAYMENTS AND REFUNDS

What You Need to Know

Section 1866j(6) of the Social Security Act authorizes the Secretary to make any necessary adjustments to the payments of a provider of services or supplier who shares a TIN with a provider of services or supplier that has an outstanding Medicare overpayment. The Secretary of Health and Human Services is authorized to adjust the payments of such a provider of services or supplier regardless of whether it has been assigned a different billing number or NPI from that of the provider of services or supplier with the outstanding Medicare overpayment.

In January 2016, the Centers for Medicare & Medicaid Services (CMS) enhanced its financial accounting system to include a function that allows CMS to recover payments made to a provider of services or supplier that shares the same TIN with a provider of services or supplier that has an outstanding Medicare overpayment across multiple states within a Medicare Administrative Contractor (MAC) jurisdiction.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work.

OXYGEN

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

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

The E0434 review involved 70 claims, of which 35 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 43%.

The E0439 review involved 105 claims, of which 56 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 51%.

The top reasons for denial were:

- Documentation does not support the treating physician has determined the beneficiary has a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy.
- Documentation does not support alternative treatment measures have been tried or considered and deemed clinically ineffective prior to initiating home oxygen therapy.
- Detailed Written Order Prior to Delivery (WOPD) is incomplete or missing elements.
- Documentation does not support the blood gas study was obtained while the beneficiary was in a chronic stable state.

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

OXYGEN

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 March 2016 through June 2016 are as follows:

The E1390 review involved 1,600 claims, of which 885 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 56%.

The top reasons for denial are:

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

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

PAP DEVICES

Documentation for DMEPOS Claims for Replacement of Essential Accessories for Beneficiary-Owned CPAP Devices and RADs

MLN Matters® Number: MM9741
Related Change Request (CR) #: CR 9741
Related CR Release Date: August 19, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R672PI
Implementation: November 2, 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) for replacement of essential accessories for beneficiary-owned Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) paid under the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

What You Need to Know

Change Request (CR) 9741 provides guidance to the MACs for handling claims for replacement of essential accessories for beneficiary-owned CPAP devices and RADs purchased by Medicare. When making a payment determination, MACs will review the necessity of replacing a CPAP or RAD accessory when the beneficiary-owned base CPAP or RAD continues to meet the medical need requirements.

Background

The Centers for Medicare & Medicaid Services (CMS) is alerting providers that due to the changing environment occurring in the DMEPOS industry, Medicare beneficiaries are having difficulty locating suppliers to replace accessories for beneficiary-owned equipment when the original supplier's documentation for the base CPAP or RAD is not available.

Your MAC will require documentation when conducting medical review of DMEPOS claims for replacement of essential accessories for beneficiary-owned CPAP or RADs.

CMS provides the following guidance to the MACs by identifying the documentation required when conducting medical review of DMEPOS claims for replacement of essential accessories for beneficiary-owned CPAP or RADs.

For purposes of reviews on replacement of accessories claims, if Medicare paid for the base CPAP or RAD initially (that is, for 13 months of continuous use), the medical necessity for the beneficiary-owned base CPAP or RAD is assumed to have been established. Even though a face-to-face encounter is required for the initial provision of the CPAP device, it is not needed for replacement of essential accessories for a patient-owned CPAP device purchased by Medicare.

Therefore, to make a payment determination MACs will only review:

- The base DME item continued medical need requirements, including documentation from the physician or treating practitioner that indicates the CPAP or RAD that requires replacement accessories continues to be medically necessary. For this purpose, documentation is considered timely when it is on record in the preceding 12 months; and
- The medical necessity of the replacement of specific accessories or furnishing of new accessories and whether they are essential for the effective use of the base DME.

Be aware that your MAC will ensure that the supplier's documentation records support the need to replace the accessory to maintain the equipment's functionality and meet the beneficiary's medical need. In the event that certain accessories are furnished for the first time, such as a heated humidifier or heated tubing, contractors will ensure that the accessories are medically necessary.

This guidance for replacement of essential accessories is to be applied only to CPAP and RADs owned by Medicare beneficiaries when Medicare initially paid for the base DME item. This guidance does not apply to CPAP or RADs when Medicare did not originally provide payment for the base item. In cases where Medicare did not originally pay for the DME item, all coverage, coding and documentation requirements in effect for the Date of Service (DOS) on the claim under review must be met.

Additional Information

The official instruction, CR9741 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R672PI.pdf.

Correct Coding – WHILL Powered Personal Mobility Devices

DME MAC Joint Publication

Revised July 21, 2016
Posted May 14, 2015

This is a revision to the article, "Correct Coding - WHILL Model A Powered Personal Mobility Device" published in May, 2015. The article is retitled as above and revised to include the WHILL Model M.

WHILL, Inc., (San Carlos, CA), is the manufacturer of WHILL powered personal mobility devices. They currently have two products, Model A and Model M.

WHILL Model A

The WHILL Model A has not been cleared by the FDA and is not considered to be a medical device. Consequently, this item is non-covered (no Medicare benefit). For Medicare billing purposes, claims for the WHILL Model A must be submitted using HCPCS code:

- **A9270 –** NONCOVERED ITEM OR SERVICE

This code is considered as all-inclusive for this product. None of the existing HCPCS codes for wheelchair bases, options, accessories, seating, etc. are appropriate for use with this product. Claims for this item using existing wheelchair related codes will be denied as incorrect coding.

WHILL Model M

The WHILL Model M received a 510(k) FDA clearance for marketing as a Class II Powered Wheelchair on February 12, 2016. A HCPCS code request for this product has not been submitted to the Pricing, Data Analysis and Coding (PDAC) Contractor. For Medicare billing purposes, claims for this device must be submitted using HCPCS code:

- **K0899 –** POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA

This code is considered as all-inclusive for this product. None of the existing HCPCS codes for wheelchair bases, options, accessories, seating, etc. are appropriate for use with this product. Claims for this item using existing wheelchair related codes will be denied as incorrect coding.

General Information

DMEPOS Suppliers are reminded that there is no Medicare reimbursement available for repairs or replacement of non-covered items.

Refer to the Power Mobility Devices, Wheelchair Options and Accessories and Wheelchair Seating LCDs and related Policy Articles for additional information on 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.

ATP RESNA Certification Requirement Reminder

Suppliers should include verification of Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) certification for the Assistive Technology Professional (ATP) involved in the selection of the wheelchair with documentation submitted in response to additional documentation requests (ADRs) for complex medical review. This is in order to ensure that the following stated requirements are fulfilled.

The following wheelchairs and accessories require that the following items are provided by a Rehabilitative Technology Supplier (RTS) that employs a RESNA-certified ATP who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient:

- **K0005:** Manual ultra-lightweight wheelchair
- **E1161:** Tilt-in-space manual wheelchair
- **K0835–K0840:** Group 2 Single Power Option PWC
- **K0841–K0843:** Group 2 Multiple Power Option PWC
- **K0848–K0855:** Group 3 PWC with no power options
- **E0986:** Push-rim activated power assist device
- **E2227:** A gear reduction drive wheel
- **E0988:** Lever activated wheel drive
- **E1002–E1010:** Power tilt and/or recline seating systems

Additional Resources for further clarification of this requirement:

- FAQ – Power Mobility Devices- Supplier ATP Involvement
- Local Coverage Determination (LCD) for Manual Wheelchair Bases LCD L11454 and related Policy Article (PA) A25378
- LCD for Power Mobility Devices L23598 and related PA A41127
- LCD for Wheelchair Options/Accessories L11462 and related PA A19846

Attestation Statements Must Accompany ADMC, PAR and PMD Claims for Medical Review

Noridian Medicare DME would like to take the opportunity to remind suppliers that an attestation statement is required for a licensed/certified medical professional (LCMP) evaluation to be considered as part of the face-to-face examination for a power mobility device. To fulfill this requirement the attestation must be signed and dated and submitted with all Power Mobility Device (PMD) claims, Prior Authorization Requests (PAR), and Advanced Determination of Medical Coverage's (ADMC) submissions.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (see Policy Article), there must be a signed and dated attestation by the supplier or LCMP that the LCMP has no financial relationship with the supplier. (**Note:** Evaluations performed by an LCMP who has a financial relationship with the supplier may be submitted to provide additional clinical information, but will not be considered as part of the face-to-face examination by the physician.)

Additional resources include the National Coverage Determination (NCD) 280.3, Local Coverage Determinations (LCDs) L23598, L11462, L15670 and Policy Articles (PA) A41127, A19846, A17265 and CMS Publication 100-8, Program Integrity Manual Chapter 3.

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

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

The K0001 review involved 786 claims, of which 511 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 60%.

The K0003 review involved 197 claims, of which 155 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 76%.

The top reasons for denial were:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- Documentation does not support the beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.
- Documentation does not support the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.
- Documentation does not support coverage criteria for K0003.

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

Changing a 7-Element Order for PMDs

To minimize possible misunderstanding, it is recommended that when the need for a correction to a 7-element-order for a Power Mobility Device (PMD) is identified, the supplier should request that the physician who completed the original 7-element-order complete and submit a new 7-element-order. For complete details, see Changing a 7-Element Order for PMDs.

POWER MOBILITY DEVICES

Face-to-Face Examination Date on 7-Element Order for Power Mobility Device Scenarios

Noridian would like to remind suppliers that the seven element order for a Power Mobility Device must include a valid date of the face to face examination. To determine what that date should be, Noridian has provided a valuable resource for you and your referrals. For complete details, please see Face-to-Face Examination Date on 7-Element Order for Power Mobility Device Scenarios.

Group 3 Complex Rehabilitative Power Wheelchair Accessories Reopening Guidance

Beginning July 5, 2016, suppliers may request a Reopening for certain wheelchair accessories furnished in connection with Group 3 complex rehabilitative power wheelchair claims for dates of service on/after January 1, 2016 which were previously processed at the blended amounts. They will be adjusted to the fee schedule amount when a request to add the KU modifier is received by the DME MAC. Read the complete article.

REIMBURSEMENT

DMEPOS Fee Schedule – July 2016 Quarterly Update

MLN Matters® umber: MM9642
Related Change Request (CR) #: CR 9642
Related CR Release Date: June 23, 2016
Effective Date: July 1, 2016
Related CR Transmittal #: R3551CP
Implementation July 5, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9642 advises providers of fee schedule amounts for codes in effect on January 1, 2016, and July 1, 2016, for all other changes. The instructions include information on the data files, update factors and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

Background

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

Payment on a fee schedule basis is required by the Social Security Act (the Act) for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102, for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office. The Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not competitive bid areas for the items, based on information from Competitive Bidding Programs (CBPs) for DME. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website (http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home). The changes for the Calendar Year (CY) 2016 are detailed in MM9431.

Adjusted Fee Schedule Amounts

The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. The adjustments to the fee schedule amounts have been phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount. As part of this update, for claims with dates of service on or after July 1, 2016, the July quarterly update files include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts. Information from CBPs that take effect on July 1, 2016 is factored into the adjusted fee schedule amounts effective on July 1, 2016, in accordance with the regulations at 42 CFR 414.210(g)(8).

Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated in accordance with 42 CFR 414.210(g)(8) when information from the CBPs is updated. Pursuant to 42 CFR §414.210(g)(4), for items where the Single Payment Amounts (SPAs) from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment would go into effect (for example, 2016 for this update) and for each subsequent year such as 2017, and 2018.

There are three general methodologies used in adjusting the fee schedule amounts:

1. **Adjusted Fee Schedule Amounts for Areas Within the Contiguous United States**

   The average of SPAs from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These regional SPAs (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). The methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (those included in more than 10 Competitive Bidding Areas (CBAs)).

   Also, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at

   42 CFR 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 CBA established for that MSA.

2. **Adjusted Fee Schedule Amounts for Areas Outside the Contiguous United States**

   Areas outside the contiguous United States (areas such as Alaska, Guam, Hawaii) receive adjusted 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.

3. **Adjusted Fee Schedule Amounts for Items Included in 10 or Fewer CBAs**

   DME items included in 10 or fewer CBAs receive adjusted 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 applies to all areas, non-contiguous and contiguous.

In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file is updated to include rural payment amounts for certain HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file, the national fee schedule amounts for enteral nutrition transitions to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology remains unchanged.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts based on information from the CBPs. ZIP codes for non-contiguous areas are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

Key Points of CR9642

Public Use Files (PUFs)

In October 2015, CMS posted sample 2016 DMEPOS and PEN Medicare payment PUFs that were modified to accommodate the adjusted fee schedule amounts effective January 1, 2016. At that time, CMS communicated that different PUF file formats would be used for the January 2016 Excel file update as opposed to the July 2016 update and all subsequent fee schedule updates. CMS has recently determined that it is necessary to retain separate rural fee fields for each state and not transition, beginning July 1, 2016, to one field titled "Contiguous United States Rural Fee" as previously communicated. Therefore, beginning with the July 2016 update, the July DMEPOS and PEN Excel PUF record layouts will retain the separate rural fees for each state as implemented January 1, 2016. As discussed above, the phase in of adjusted fees are based on 100 percent of the adjusted fee schedule amounts effective July 1, 2016. The rural fee for the contiguous United States, which is equal to the national ceiling amount, applies to all rural areas within the contiguous United States. However, in any case where the application of the adjusted fee methodology results in an increase in the fee schedule amount that would otherwise apply, the rural adjustment for an area/state is not made. Non-contiguous areas are not subject to rural fees under the CY 2016 DMEPOS fee schedule methodology.

The CY 2016 DMEPOS and PEN fee schedules and the July 2016 DMEPOS Rural ZIP code file PUFs will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched.

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

Section 2 of the Patient Access and Medicare Protection Act (PAMPA) mandates that the adjustments to the CY 2016 fee schedule amounts for certain DME based on information from CBPs not be applie to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017. Group 3 complex rehabilitative power wheelchair bases are currently described by codes K0848 through K0864 of the HCPCS.

As a result, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are included in the July 2016 DMEPOS fee schedule file and are effective for dates of service January 1, 2016, through December 31, 2016. The fee schedule amounts associated with the KU modifier represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated by the 2016 DMEPOS covered item update factor of -0.4 percent) for these wheelchair accessory codes.

The codes for wheelchair accessories and seat and back cushions affected by this change along with claims processing instructions are available in CR9520 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3535CP.pdf. In accordance with that article, if brought to their attention, MACs may adjust claims for the Group 3 complex rehabilitative power wheelchair accessories referenced in Attachment A of related CR9520 for dates of service January 1, 2016, through June 30, 2016.

Discontinuation of KE Modifier for Items in Initial Round 1 CBP

As part of this update, the fees for certain items included in Round 1 CBP, denoted with the HCPCS pricing modifier 'KE', are deleted from the DMEPOS fee schedule file. Program instructions on the implementation of these fees and the list of applicable HCPCS codes were issued via CR6720, dated November 7, 2008 (see related article MM6720).

The KE fees were retained on the fee schedule file for dates of service January 1, 2016, through June 30, 2016, because of the phase-in of the adjusted fee schedule amounts, but are no longer needed.

Reclassification of Certain DME Included in CBPs

As part of this update, capped rental fees are established for payment of the following 14 HCPCS codes: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, these HCPCS codes are reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the 9 Round 1 Re-compete (Round 1 2014) CBAs. These changes are made to align the payment with the regulatory definition of routinely purchased equipment. Articles MM8822 and MM8566 discuss these program instructions.

When submitting claims, suppliers in areas outside of Round 1 Re-compete CBAs that furnish these 14 HCPCS codes on a capped rental basis use the capped rental modifiers KH, KI, and KJ as appropriate. Beginning January 1, 2017, payment for these codes in all geographic areas will be made on a capped rental basis.

Also, certain HCPCS codes for wheelchair options/accessories (E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955) that are furnished to be used as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) can be paid under the associated lump sum purchase option set forth in article MM8566.

The supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished for initial or replacement. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment shall be made on a monthly rental basis in accordance with the capped rental payment rules.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order DTS without KL modifier for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4258 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they were equal to the SPAs for mail order DTS established in implementing the national mail-order CBP under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file are updated each time the single payment amounts are updated. As part of the this update, the non-mail order payment amounts on the fee schedule file for the above codes will be updated, effective July 1, 2016, using the SPAs established under the National Mail-Order Re-compete CBP.

As part of this update, the DTS mail order (with KL modifier) fee schedules for all states and territories are removed from the DMEPOS fee schedule file. The SPAs calculated under the National Mail-Order CBPs replace the mail order fee schedule amounts for diabetic testing supply codes listed above. The SPAs are available at http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with Section 42 Code of Federal Regulations (CFR) 414.210(g) (7), the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the SPAs established under the national mail-order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the 6-month transition phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which were based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order SPAs, were provided on the DMEPOS fee schedule file in the Hawaii column of the 8 mail-order (KL) DTS codes listed above for dates of service January 1, 2016, through June 30, 2016.

Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. As part of this update, the Northern Mariana Island DTS transition mail-order payment amounts will no longer appear in the Hawaii column of the fee schedule file and the DTS mail order (KL) fee schedules for all states and territories are removed from the DMEPOS fee schedule file as of July 1, 2016.

Specific Coding and Pricing Issues

As part of this update, fees are established for HCPCS codes A6450 and A6451 which were added to the HCPCS file in CY 2004. Claims for codes A6450 and A6451 with dates of service on or after January 1, 2016, that have already been processed may be adjusted to reflect the newly established fees if brought to your MAC's attention.

Additional Information

The official instruction, CR9642 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3551CP.pdf on the CMS website.

42 CFR 414.202 is available at https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec414-202.

Revised Fee Schedules for E1012 in Association with Change Request 9642

MLN Matters® Number: MM9692
Related Change Request (CR) #: CR 9692
Related CR Release Date: June 23, 2016
Effective Date: January 1, 2016
Related CR Transmittal #: R1677OTN
Implementation July 5, 2016

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, specifically Healthcare Common Procedure Coding System (HCPCS) Code E1012, paid under the DMEPOS fee schedule.

Provider Action Needed

An error was made in the calculation of the fee schedule for code E1012. Change Request (CR) 9692 corrects that error and provides instructions regarding the revision of the Calendar Year (CY) 2016 fee schedule amounts for HCPCS Code E1012 (wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each). Make sure your billing staffs are aware of these changes.

Key Points

The fee schedule amounts for this code have been revised in order to correct errors made in the calculation of the fee schedule for code E1012.

1. Your MAC will process claims for E1012 with dates of service on or after January 1, 2016, using the revised E1012 fee schedule amounts included in the DMEPOS fee schedule files communicated under the July Quarterly DMEPOS Fee Schedule Update CR9642.
2. Claims for code E1012 with dates of service or after January 1, 2016 that have already been processed will be adjusted if you bring such claims to the attention of your MAC.

Additional Information

The official instruction, CR9692, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1677OTN.pdf on the CMS website.

DMEPOS Fee Schedule – October 2016 Quarterly Update

MLN Matters® Number: MM9756
Related Change Request (CR) #: CR 9756
Related CR Release Date: August 26, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3598CP
Implementation: October 3, 2016

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9756 advises providers of fee schedule amounts for codes in effect on October 1, 2016. Make sure your billing staffs are aware of these updates.

Key Points

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedules on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60.

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

October quarterly updates are only required for the DMEPOS Rural ZIP Code file containing Quarter 4, 2016 Rural ZIP Code changes. MACs will process claims for DMEPOS items using the Rural ZIP code file for dates of service on or after October 1, 2016.

The October 2016 DMEPOS Rural ZIP Code Public Use File (PUF), containing the rural ZIP codes effective for Quarter 4, 2016, will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the above PUF.

Additional Information

The official instruction, CR 9756, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3598CP.pdf.

Chapter 23 of the "Medicare Claims Processing Manual" is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf.

TENS

Transcutaneous Electrical Nerve Stimulator (TENS) (HCPCS E0730) 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(s) E0730. This review was initiated based on data analysis that identified changes in billing patterns.

The E0730 review involved 119 claims, of which 115 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

The top reasons for denial are:

- Documentation does not support the reevaluation of the beneficiary at the end of the trial period.
- Documentation does not support other treatments have been tried or failed and pain has been present for at least three months.
- Documentation does not contain a valid date stamp or similar.
- Documentation does not support why two leads are insufficient to meet the beneficiary's needs.

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

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 March 2016 through June 2016 are as follows:

The A5500 review involved 3,652 claims, of which 2,737 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 76%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support the certifying physician has documented in the beneficiary's medical record one of the specified conditions:
- Documentation of the in-person with supplier at the time of delivery is incomplete.
- Documentation does not support the certifying physician has certified that indications one and two are met and that he/she is treating the beneficiary under a comprehensive plan of care for his/her diabetes and that the beneficiary needs diabetic shoes.

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

Claim Status Category and Claim Status Codes Update

MLN Matters® Number: MM9680
Related Change Request (CR) #: CR 9680
Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3599CP
Implementation Date: January 3, 2017

Provider Types Affected

This MLN Matters® Article is intended for physicians, 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.

What You Need to Know

Change Request (CR) 9680 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgement transactions.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use only Claim Status Category Codes and Claim Status Codes approved by the National Code Maintenance Committee in the ASC X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276.277 transactions to report claim status.

The National Code Maintenance Committee (NCMC) meets at the beginning of each ASC X12 trimester meeting (January/February, June, and September/October) and makes decisions about additions, modifications, and retirement of existing codes. The NCMC allows the industry 6 months for implementation of newly added or changed codes. Codes sets are available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-category-codes/ and http://www.wpc-edi.com/reference/codelists/healthcare/claim-status-codes/. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the September/October 2016 committee meeting shall be posted on these sites on or about November 1, 2016. MACs will complete entry of all applicable code text changes and new codes, and terminated use of deactivated codes, by the implementation of CR9680.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date CR9680 is implemented.

MACs must comply with the requirements contained in the current standards adopted under HIPAA for electronically submitting certain health care transactions, among them the ASC X12 276/277 Health Care Claim Status Request and Response. The MACs must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses. They must also use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Healthcare Claim Acknowledgments. References in this CR to "277 responses" and "claim status responses" encompass both the ASC X12 277 Health Care Claim Status Response and the ASC X12 277 Healthcare Claim Acknowledgment transactions.

Additional Information

The official instruction, CR9680, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3599CP.pdf.

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM9695
Related Change Request (CR) #: CR 9695
Related CR Release Date: July 15, 2016
Effective Date: October 1, 2016
Related CR Transmittal #: R3562CP
Implementation Date: October 3, 2016

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9695 informs MACs about the changes that update the Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) lists, and CR9695 calls for an update to the Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes. If you use the MREP and/or PC Print software, be sure to obtain the latest version that is released on or before October 3, 2016.

Background

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

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

CR9695 is a code update notification indicating when updates to CARC and RARC lists are made available on the Washington Publishing Company (WPC) website. Medicare's Standard System Maintainers (SSMs) have the responsibility to implement code deactivation, making sure that any deactivated code is not used in original business messages and allowing the deactivated code in derivative messages. SSMs must make sure that Medicare does not report any deactivated code on or after the effective date for deactivation as posted on the WPC website. If any new or modified code has an effective date past the implementation date specified in CR9695, MACs must implement on the date specified on the WPC website at http://wpc-edi.com/Reference/.

A discrepancy between the dates may arise as the WPC website is only updated 3 times a year and may not match the CMS release schedule.

Additional Information

The official instruction, CR9695, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3562CP.pdf.

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

MLN Matters® Number: MM9696
Related Change Request (CR) #: CR 9696
Related CR Release Date: July 1, 2016
Effective Date: October1, 2016
Related CR Transmittal #: R3558CP
Implementation Date: October 3, 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

This article is based on Change Request (CR) 9696 which instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule publication. These system updates reflect the Committee on Operating Rules for Information Exchange (CORE) Code Combination List for June 2016. Make sure that your billing staff is aware of these changes. In addition, if you use the PC Print or Medicare Remit Easy Print (MREP) software supplied by your MAC, be sure to obtain the updated version of that software when it is available.

Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and disappointing.

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions by mandating the adoption of a set of operating rules for each of the HIPAA transactions.

CAQH CORE lists the June 2016 version on the Code Combination List website. This update includes CARC and RARC updates as posted at the Washington Publication Company (WPC) website on or about March 1, 2016. This will also include updates based on Market Based Review (MBR) that the CAQH CORE conducts once a year to accommodate code combinations that are currently being used by Health Plans including Medicare as the industry needs them.

Medicare can use any code combination if the business scenario is not one of the 4 CORE defined business scenarios. With the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE.

Additional Information

The official instruction, CR9696, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3558CP.pdf on the CMS website.

The WPC website is at http://www.wpc-edi.com/reference/.

The CAQH CORE Code Combination List is available at http://www.caqh.org/CORECodeCombinations.php.

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

MLN Matters® Number: MM9766
Related Change Request (CR) #: CR 9766
Related CR Release Date: August 26, 2016
Effective Date: January 1, 2017
Related CR Transmittal #: R3600CP
Implementation Date: January 3, 2017

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9766 informs MACs of the regular update in the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule. Make sure that your billing staffs are aware of these changes.

Background

The Department of Health and Human Services (HHS) adopted the Phase III CAQH CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Patient Protection and Affordable Care Act. The Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of HHS (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

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

CR9766 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

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

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

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

Additional Information

The official instruction, CR9766, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3600CP.pdf.

UPDATES

Update to Requirements for Miscellaneous Healthcare Common Procedure Coding System (HCPCS) Codes

Items billed with a miscellaneous HCPCS code require the following documentation to be submitted with the claim:

- Description of the item or service
- Manufacturer name
- Product name and number

Miscellaneous HCPCS codes billed without this information will be denied for missing documentation and will need to be resubmitted with the missing information.

Suggested Retail Price (SRP) has been removed from the list of required documentation. While the supplier can still submit the SRP with their claim to help identify the item billed, the DME MACs will not use this information in determination of reimbursement. If the DME MACs need pricing information to help in their reimbursement determination, they will send a development letter requesting the Supplier provide a Price List which includes the item billed.

Suppliers billing miscellaneous-coded products are reminded that items that have a specific HCPCS code must not be billed with miscellaneous HCPCS codes. Inappropriate billing of miscellaneous HCPCS codes can result in a claim return/reject or denial of the HCPCS code for invalid coding.

Questions concerning HCPCS code classifications should be directed to the Pricing, Data Analysis and Coding (PDAC) contractor - 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/

Refer to the applicable Local Coverage Determinations (LCDs) and related Policy Articles for additional information on requirements for miscellaneous HCPCS codes.

UROLOGICAL SUPPLIES

Urological Supplies (HCPCS A4326) 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 A4326. This review was initiated based on data analysis that identified changes in billing patterns.

The A4326 review involved 107 claims, of which 94 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 85%.

The top reasons for denial are:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support medical necessity of a specialty type male catheter.
- Documentation does not support a permanent urinary incontinence or retention.
- Medical documentation was not received.

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

Urinary Drainage Systems

For an item to be considered under the Urological Supplies policy, the beneficiary must have permanent urinary incontinence or permanent urinary retention. Payment will be made for routine changes of the urinary drainage collection system under the Urological Supplies policy if all coverage criteria is met. These codes include A4314-A4316, A4354, A4357, A4358, A5102 and A5112.

For an item to be considered under the Ostomy Supplies policy, the beneficiary must have a surgically created opening (stoma) to divert urine, or fecal contents outside the body. Ostomy supplies are appropriately used for colostomies, ileostomies or urinary ostomies. A urinary ostomy pouch will be covered under the Ostomy Supplies policy if all coverage criteria is met. A pouch is a device for collecting stomal output. A "urinary" pouch normally incorporates anti-reflux devices and a tap or spigot to empty the urine contents. These codes include A4379-A4383, A4391-A4393, A4428-A4434 and A5071-A5073. Beneficiaries with urinary ostomies may use either a bag (A4357) or bottle (A5102) for drainage at night, which will be covered under the Ostomy Supplies policy if all coverage criteria is met.

Please note HCPCS code A4358 (URINARY DRAINAGE BAG, LEG OR ABDOMEN, VINYL, WITH OR WITHOUT TUBE, WITH STRAPS, EACH) is not contained in the Ostomy Supplies policy and will be denied as not reasonable and necessary when used with an ostomy.

Please contact Medicare Pricing, Data Analysis and Coding (PDAC) at 877-735-1326 or visit https://www.dmepdac.com/ for more information on the coding and billing of these products.

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

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

- The A4351 review involved 1,988 claims, of which 1,122 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 51%.
- The A4353 review involved 292 claims, of which 232were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 75%.
- The A4358 review involved 1,511 claims, of which 1,221 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 76%.

The top reasons for denial were:

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical documentation was not received.
- Documentation does not support a permanent urinary incontinence or retention.
- Documentation does not support that the beneficiary requires catheterization and meets at least one of the listed criteria.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Refill request is incomplete or missing elements.

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

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