# DME Happenings

Jurisdiction D
Issue No. 49
December 2015

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### APPEALS



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

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Noridian Healthcare Solutions, LLC

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# Alphabetical Listing

## Jurisdiction D DME MAC Supplier Contacts and Resources

| Phone Numbers | | |
|---|---|---|
| **Interactive Voice Response System** | 1-877-320-0390 | 24 hours a day, 7 days a week for Eligibility and general information<br>6 am – 8 pm CT<br>Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status |
| **Supplier Contact Center** | 1-877-320-0390 | 8 am – 6 pm CT Monday-Friday |
| **Telephone Reopenings** | 1-877-320-0390 | 8 am – 4:30 pm CT |
| **Beneficiary Customer Service** | 1-800-633-4227 | 24 hours a day/7 days a week |
| **Website: www.noridianmedicare.com/dme** | | |
| **Fax** | | |
| **Reopenings and Redeterminations**<br>**MSP Inquiries and Refunds**<br>**DME Recovery Auditor Redeterminations** | | 1-701-277-7886 |
| **Refunds to Medicare**<br>**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**<br>Noridian<br>PO Box 6727<br>Fargo ND 58108-6727 | | **Benefit Protection**<br>Noridian<br>Benefit Protection-DME<br>PO Box 6736<br>Fargo ND 58108-6736 |
| **Administrative Simplification Compliance Act Exception Requests**<br>Noridian<br>PO Box 6737<br>Fargo ND 58108-6737 | | **Qualified Independent Contractor**<br>C2C Solutions, Inc.<br>Attn: DME QIC<br>PO Box 44013<br>Jacksonville FL 32231-4013 |
| **Electronic Funds Transfer Forms/ Overpayment Redeterminations/ DME Recovery Auditor Redeterminations**<br>Noridian<br>PO Box 6728<br>Fargo ND 58108-6728 | | **DME Recovery Auditor Overpayments**<br>Noridian<br>PO Box 6759<br>Fargo ND 58108-6759 |

## CONTACT US

| Other DME MACs | | |
|---|---|---|
| **Jurisdiction A: NHIC, Corp** | 1-866-419-9458 | www.medicarenhic.com |
| **Jurisdiction B: National Government Services** | 1-877-299-7900 | www.ngsmedicare.com |
| **Jurisdiction C: CGS** | 1-866-270-4909 | www.cgsmedicare.com |
| **Other Resources** | | |
| **Pricing, Data Analysis and Coding** | 1-877-735-1326 | www.dmepdac.com |
| **National Supplier Clearinghouse** | 1-866-238-9652 | www.palmettogba.com/nsc |
| **Common Electronic Data Interchange Help Desk** | 1-866-311-9184 | www.ngscedi.com |
| **Centers for Medicare & Medicaid Services** | | www.cms.gov |

## FYI

# 2015 Supplier Contact Center and Telephone Reopenings Holiday and Training Closures

### Supplier Contact Center

The Noridian Customer Service team (1-877-320-0390) will be closed for the entire day (8 a.m. through 6 p.m. CT) in recognition of holidays. Additionally, the Customer Service team will be closed three days each month to receive training from 9:30 a.m. – 12 p.m. CT. The holiday and training closures are provided below. The Interactive Voice Recognition (IVR) [PDF] system (1-877-320-0390) and Endeavor, the Noridian DME Jurisdiction D supplier portal, will each continue to be available on these dates to assist suppliers with their claim status, eligibility, remittance advice, same and/or similar inquiries

| Event | Date | Closure Timeframe |
|---|---|---|
| **Good Friday** | April 3, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | April 10, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | April 17, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | April 24, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | May 8, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | May 15, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | May 22, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Memorial Day** | May 25, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | June 12, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | June 19, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | June 26, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Independence Day Observance** | July 3, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | July 10, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | July 17, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | July 24, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | August 14, 2015 | 9:40 a.m. – 12 p.m. CT |

| Event | Date | Closure Timeframe |
|---|---|---|
| **Off-the-Phone Training** | August 21, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | August 28, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Labor Day** | September 7, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | September 11, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | September 18, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | September 25, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | October 9, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Columbus Day Training** | October 12, 2015 | 2:00 p.m. – 6 p.m. CT |
| **Off-the-Phone Training** | October 16, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | October 23, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | November 13, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | November 20, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Thanksgiving** | November 26 and 27, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | December 11, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | December 18, 2015 | 9:40 a.m. – 12 p.m. CT |
| **Christmas** | December 24, 2015 | 12 – 6 p.m. CT |
| **Christmas** | December 25, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |

## Telephone Reopenings

The Noridian Telephone Reopening Team will be closed for the entire day (8 a.m. through 4:30 p.m. CT) in recognition of holidays. Additionally, the Telephone Reopening team will be closed the first Friday of each month between 8 a.m. and 10 a.m. CT and the second through fourth Fridays of each month from 9:30 a.m. – 12 p.m. to receive training. The holiday and training closures are provided below.

| Event | Date | Closure Timeframe |
|---|---|---|
| **Good Friday** | April 3, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | April 10, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | April 17, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | April 24, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | May 1, 2015 | 9:30 – 10:30 a.m. CT |
| **Off-the-Phone Training** | May 8, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | May 15, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | May 22, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Memorial Day** | May 25, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | June 5, 2015 | 9:30 – 10:30 a.m. CT |
| **Off-the-Phone Training** | June 12, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | June 19, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | June 26, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Independence Day Observance** | July 3, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |

| Event | Date | Closure Timeframe |
|---|---|---|
| **Off-the-Phone Training** | July 10, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | July 17, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | July 24, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | August 7, 2015 | 9:30 – 10:30 a.m. CT |
| **Off-the-Phone Training** | August 14, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | August 21, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | August 28, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | September 4, 2015 | 9:30 – 10:30 a.m. CT |
| **Labor Day** | September 7, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | September 11, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | September 18, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | September 25, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | October 2, 2015 | 9:30 – 10:30 a.m. CT |
| **Off-the-Phone Training** | October 9, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Columbus Day Training** | October 12, 2015 | 2 – 6 p.m. CT |
| **Off-the-Phone Training** | October 16, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | October 23, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | November 6, 2015 | 9:30 – 10:30 a.m. CT |
| **Off-the-Phone Training** | November 13, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | November 20, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Thanksgiving** | November 26 and 27, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |
| **Off-the-Phone Training** | December 4, 2015 | 9:30 – 10:30 a.m. CT |
| **Off-the-Phone Training** | December 11, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Off-the-Phone Training** | December 18, 2015 | 9:30 a.m. – 12 p.m. CT |
| **Christmas** | December 24, 2015 | 12 – 6 p.m. CT |
| **Christmas** | December 25, 2015 | Entire Day Closed<br>8 a.m. – 6 p.m. CT |

## Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

## Beneficiaries Call 1-800-MEDICARE

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

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

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

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

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

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

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

## CMS Quarterly Provider Updates

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

The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;

- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

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

## Medicare Learning Network Matters Disclaimer Statement

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

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

## Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D Happenings" is to educate Noridian's Durable Medical Equipment supplier community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes "Source" following CMS derived articles to allow for those interested in the original material to research it at CMS's website, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

## Fax Reminders for ADR Responses

In order to ensure prompt and accurate processing of faxed documentation, Noridian encourages suppliers to follow a few basic tips when responding to Additional Documentation Requests (ADR) via fax.

- **Submit the original ADR letter as the first page of each fax submission.**
  Noridian urges suppliers to include the original ADR letter as the first page of a supplier's claim submission followed by any required medical records or documentation. This will ensure the bar code listed on the ADR is able to electronically align the documentation and the corresponding claim. The use of a fax coversheet may impair the scanners' ability to read the barcode.
- **Ensure the document being faxed is clear and legible.**
  Noridian strongly encourages suppliers to return the original ADR letter as the first page of a faxed response as imaged copies may appear illegible.
- **Submit each individual ADR response as a separate fax.**
  When multiple responses are combined into a single fax, the likelihood of a delay in processing is increased.
- **Avoid submitting duplicate responses.**
  Sending duplicate responses may increase the processing and/or response time.
- **Include all documents needed for an ADR response in a single fax submission.**
  Noridian encourages suppliers to avoid submitting multiple faxes for one response or request in order to avoid processing delays.

- **Submit each ADR response to the fax number listed on the ADR letter.**
  When faxed responses are sent to an incorrect department, the processing and/or response time may increase.

Additional information and resources regarding other important Medicare topics are located in the DME MAC Jurisdiction D Supplier Manual. If you need additional assistance, please contact our Supplier Contact Center at 877-320-0390.

## MLN Connects® Provider eNews – September 3, 2015

MLN Connects® Provider eNews for Thursday, September 3, 2015

View this edition as a PDF

### In This Edition:

**Countdown to ICD-10**

- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- "General Equivalence Mappings Frequently Asked Questions" Booklet – Revised
- "ICD-10-CM/PCS ICD-10-CM/PCS Myths and Facts" Fact Sheet – Revised
- "ICD-10-CM Classification Enhancements" Fact Sheet – Revised
- "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet – Revised
- Get Ready Now: Assess How ICD-10 Will Affect Your Practice
- Prepare for ICD-10 with MLN Connects Videos

**MLN Connects® National Provider Calls and Events**

- Overview of the 2014 Annual Quality and Resource Use Reports Webcast – Register Now
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Registration Now Open
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Register Now

**Announcements**

- CMS to Extend Initiative to Improve Care for Nursing Facility Residents
- DMEPOS Competitive Bidding Program: Prepare for Round 1 2017
- New ST PEPPER Available
- EHR Incentive Programs: Determine Broadband Speed in Your Area

**Claims, Pricers, and Codes**

- October 2015 Average Sales Price Files Now Available

**Medicare Learning Network® Educational Products**

- "837P and Form CMS-1500" Web-Based Training Course – Revised

## MLN Connects® Provider eNews – September 10, 2015

MLN Connects® Provider eNews for September 10, 2015

View this edition as a PDF

### In This Edition:

**Countdown to ICD-10**

- Updated Results for ICD-10 End-to-End Testing Week in July
- ICD-10 Coding and Clinical Documentation Resources

- New Webcasts Cover Dental, Lab, Pharmacy, and Radiology Services
- Audio Recording and Written Transcript from August 27 MLN Connects Call Available
- Finding ICD-10 Information Online Just Got Easier
- Revised ICD-10 Products Now Available in Hard Copy Format

**MLN Connects® National Provider Calls and Events**

- Overview of the 2014 Annual Quality and Resource Use Reports Webcast – Last Chance to Register
- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Register Now
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Register Now
- Dialysis Facility Compare: Rollout of Five Star Rating Call – Registration Now Open
- 2014 Supplemental QRUR Physician Feedback Program Call – Registration Now Open

**Announcements**

- HIV Screening for Older Adults and Others with Medicare
- 2014 Annual Quality and Resource Use Reports Available Soon
- CMS to Release CBR on Orthopedic Surgeons' Use of Modifiers 24 and 25 in September

**Claims, Pricers, and Codes**

- Delay in Implementing Single Chamber and Dual Chamber Cardiac Pacemakers

**Medicare Learning Network® Educational Products**

- "Skilled Nursing Facility (SNF) Consolidated Billing (CB)" Web-Based Training Course – Revised
- "HIPAA EDI Standards" Web-Based Training Course – Revised

## MLN Connects® Provider eNews – September 17, 2015

MLN Connects® Provider eNews for September 17, 2015

View this edition as a PDF

### In This Edition:

**Countdown to ICD-10**

- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Use of Unspecified Codes in ICD-10-CM
- Get ICD-10 Answers in One Place

**MLN Connects® National Provider Calls and Events**

- Hospital Inpatient and LTCH PPS FY 2016 Final Rule Call – Last Chance to Register
- Medicare Quality Reporting Programs: 2017 Payment Adjustments Call – Last Chance to Register
- Dialysis Facility Compare: Rollout of Five Star Rating Call – Register Now
- 2014 Supplemental QRUR Physician Feedback Program Call – Register Now
- Improving Medicare Post-Acute Care Transformation Act – Registration Now Open

**Other CMS Events**

- Physician Compare Public Reporting Information Sessions
- Medicare Learning Network Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund

**Announcements**

- Medicare-Covered Cardiovascular Disease Preventive Services
- Healthy Aging Month – Discuss Preventive Services with your Patients
- CMS Releases Plan to Address Health Equity in Medicare
- Early Flu Treatment Reduces Hospitalization Time, Disability Risk in Older People
- 2016 PQRS Payment Adjustment and Informal Review Process
- Million Hearts: Cardiovascular Disease Risk Reduction Model Application Deadline Extension

**Medicare Learning Network® Educational Products**

- "Medicare-Required SNF PPS Assessments" Educational Tool – Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" MLN Matters Article – Revised

## MLN Connects® Provider eNews – September 24, 2015

MLN Connects® Provider eNews for September 24, 2015

View this edition as a PDF

### In This Edition:

**Countdown to ICD-10**

- Use ICD-10 to Successfully Bill for Your Services
- Clarifying Questions and Answers Related to the CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities – Update
- Access the ICD-10 Code Set
- List of Valid ICD-10-CM Codes
- Claims that Span the ICD-10 Implementation Date
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Get ICD-10 Answers in One Place

**MLN Connects® National Provider Calls and Events**

- Dialysis Facility Compare: Rollout of Five Star Rating Call – Register Now
- 2014 Supplemental QRUR Physician Feedback Program Call – Register Now
- Improving Medicare Post-Acute Care Transformation Act – Register Now
- New MLN Connects National Provider Event Audio Recording and Transcript

**Other CMS Events**

- Medicare Learning Network Webinar: Medicare Basics for New Providers Part Three: Medicare Claim Review Programs, POE, and Protecting the Medicare Trust Fund
- Long-Term Care Hospital Quality Reporting Program Provider Training

**Announcements**

- September is Prostate Cancer Awareness Month
- Prepare for DMEPOS Competitive Bidding Round 1 2017: Three Steps to Get Ready
- EHR Incentive Program 2016 Payment Adjustment Fact Sheet for Hospitals Available

**Medicare Learning Network® Educational Products**

- "PECOS for Physicians and Non-Physician Practitioners" Fact Sheet – Revised
- Medicare Learning Network Product Available In Electronic Publication Format

## MLN Connects® Provider eNews – October 1, 2015

MLN Connects® Provider eNews for October 1, 2015

View this edition as a PDF

### In This Edition:

**ICD-10**

- Coding around the Compliance Date
- Physician Orders for Lab, Radiology Services, and Other Services after ICD-10 Implementation
- Access the ICD-10 Code Set
- Finding ICD-10 Information Online

**MLN Connects® National Provider Calls and Events**

- Dialysis Facility Compare: Rollout of Five Star Rating Call – Last Chance to Register
- 2014 Supplemental QRUR Physician Feedback Program Call – Register Now
- Improving Medicare Post-Acute Care Transformation Act – Register Now
- New MLN Connects Event Video Slideshows, Audio Recordings, and Transcripts

**MLN Connects Videos**

- Video Available on PQRS and VM: What You Need to Know in 2015

**Other CMS Events**

- Webinar for Comparative Billing Report on Modifiers 24 and 25: Orthopedic Surgeons

**Announcements**

- Talk to Your Patients about Mental Illness and Depression
- CMS Proposes New Medicare Clinical Diagnostic Laboratory Tests Fee Schedule
- HHS Announces $685 Million to Support Clinicians Delivering High Quality, Patient-Centered Care
- CMS Awards $110 Million to Continue Improvements in Patient Safety
- 2014 Supplemental Quality and Resource Use Reports Available
- MACRA: New Opportunities for Medicare Providers through Innovative Payment Systems
- Getting Started with the Hospice Item Set: Updated Fact Sheet Available
- Access Ordering and Referring Report through data.cms.gov
- Change in Cost Report Appeals Support Contractor for Part A Providers
- New EHR Web Page for Past Program Requirements and Resources
- Guidance on Switching EHR Vendors
- 2016 PQRS Payment Adjustment and Informal Review Process

**Medicare Learning Network® Educational Products**

- "Medicare Enrollment and Claim Submission Guidelines" Booklet – Revised
- "Medicare Enrollment for Institutional Providers" Fact Sheet – Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

# MLN Connects® Provider eNews Special Edition – October 5, 2015

## DMEPOS Fee Schedule PUF Formats and Rural Zip Code File

CMS released revised Public Use File (PUF) formats for the CY 2016 Durable Medical Equipment Prosthetics Orthotics Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) fee schedules. A preliminary DMEPOS rural ZIP Code file containing Quarter 4 2015 rural ZIP codes was also released. More information on these files is available on the Durable Medical Equipment Center web page.

# MLN Connects® Provider eNews – October 8, 2015

MLN Connects® Provider eNews for October 08, 2015

View this edition as a PDF

## In This Edition:

**ICD-10**

- Get ICD-10 Answers in One Place
- 5 Ways to Check Your Claim Status

**MLN Connects® National Provider Calls and Events**

- 2014 Supplemental QRUR Physician Feedback Program Call – Last Chance to Register
- Improving Medicare Post-Acute Care Transformation Act – Register Now
- New MLN Connects National Provider Call Audio Recordings and Transcripts

**Other CMS Events**

- MACRA Request for Information Webinars

**Announcements**

- DMEPOS Competitive Bidding Round 1 2017 Bidding Starts October 15
- HHS Issues Rules to Advance Electronic Health Records with Added Simplicity and Flexibility
- Physician Compare Preview Period Open through November 6
- DMEPOS Fee Schedule PUF Formats and Rural Zip Code File
- October Quarterly Provider Update Available
- Technical Correction to FY 2015 IPF Final Rule
- Participation in EHR Incentive Programs: Updated FAQs

**Claims, Pricers, and Codes**

- October 2015 OPPS Pricer File Available

**Medicare Learning Network® Educational Products**

- "How to Access and Use the Medicare Learning Network Learning Management and Product Ordering System (LM/POS)" Fact Sheet – Released
- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet – Revised
- "DMEPOS Information for Pharmacies" Fact sheet – Revised
- Medicare Learning Network Products Available in Electronic Publication Format

# MLN Connects® Provider eNews – October 15, 2015

MLN Connects® Provider eNews for October 15, 2015

View this edition as a PDF

## In This Edition:

**ICD-10**

- Use ICD-10 Now
- ICD-10 Ombudsman and ICD-10 Coordination Center Support Your Transition Needs
- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

**MLN Connects® National Provider Calls and Events**

- Improving Medicare Post-Acute Care Transformation Act Call – Last Chance to Register
- Stay Informed about Medicare Program Changes

**Other CMS Events**

- Long-Term Care Hospital Quality Reporting Program Provider Training

**Announcements**

- CMS Launches New ACO Dialysis Model
- New Medicare Utilization and Payment Data Available for Medical Equipment, Supplies
- Primary Care Makes Strides in Improving Quality and Costs
- CMS to Release a Comparative Billing Report on Optometry Services in October
- EHR Incentive Program: 2016 Payment Adjustments and Reconsiderations

**Medicare Learning Network® Educational Products**

- "Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 1]" Educational Tool – Released
- Medicare Learning Network Products Available in Hard Copy Format
- Medicare Learning Network Product Available In Electronic Publication Format

# MLN Connects® Provider eNews Special Edition – October 15, 2015

## Bidding Now Open for Round 1 2017 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) is now soliciting bids for Round 1 2017 of the Medicare DMEPOS Competitive Bidding Program.

**All bids must be submitted in DBidS, the online bidding system, before 9:00 p.m. prevailing Eastern Time on December 16, 2015. All required hardcopy documents that must be included as part of the bid package must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before December 16, 2015.**

All bidders must submit certain required hardcopy documents as specified in the Request for Bids (RFB) instructions. CMS urges all bidders to take advantage of the covered document review process. Under this process, suppliers whose hardcopy financial documents are received by the CBIC by the covered document review date (CDRD) are notified if any individual financial documents are missing and have an opportunity to submit the missing documents. **The CDRD for Round 1 2017 is November 16, 2015. Financial documents must be RECEIVED on or before November 16, 2015, to qualify for the covered document review process.**

To bid, go to the CBIC website at www.dmecompetitivebid.com and click on Round 1 2017. Next, click on BIDDING IS OPEN above the bidding clock on that page. Prior to submitting your bid(s), we strongly recommend that you:

- Review the RFB
- Watch the following short and very helpful instructional videos
  - How to Complete Form A
  - How to Complete Form B
  - Submitting Hardcopy Documents
- Review the fact sheets, user guides, checklists and bid preparation worksheets on the CBIC website
- Ensure the accuracy of the information on your CMS-855S enrollment application(s) with the National Supplier Clearinghouse (NSC) and in the Provider Enrollment, Chain and Ownership System (PECOS)

Ensure that licensure and accreditation for each location on your bid(s) is up to date and on file with the NSC and in PECOS. Licensing requirements change periodically, and it remains the responsibility of the bidding supplier to identify and obtain all required licenses

## Registration

The target registration date for authorized officials (AOs) to register for a user ID and password in CMS' Enterprise Identity Management (EIDM) system has passed. Backup authorized officials (BAOs), end users (EUs), as well as any AOs who have not yet registered, should now be registering. Only suppliers that have an EIDM user ID and password and have added access the online bidding system, DBidS, will be able to submit bids. If you do not complete registration by adding access to the DBidS application, you cannot bid and will not be eligible for a contract. Don't delay—suppliers whose AOs have not registered are at risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the CDRD.

**Registration for everyone will close on November 20, 2015, at 9 p.m. prevailing Eastern Time – no AOs, BAOs, or EUs can register after registration closes.**

To register,visit the CBIC website and click on Round 1 2017. Next, click on *REGISTRATION IS OPEN* above the registration clock on that page. Please note that suppliers with multiple locations should register only ONE time and with ONE Provider Transaction Access Number (PTAN) and will submit the bids for additional locations in DBidS.

The ONLY two exceptions are:

- If you are bidding both as the primary network member and independently in another CBA and product category competition(s); and
- If your organization has separate entities – such as subsidiaries or commonly owned and/or commonly controlled organizations – that are bidding in a separate CBA and product category combination

If either of these two exceptions applies, you should then register a different PTAN for each type of bid.

If you have any questions about the registration process, please refer to the RFB instructions or contact the CBIC customer service center. Prior to registering, we strongly recommend that you:

- Carefully read the RFB,
- Review the EIDM Reference Guide, and
- Use the EIDM Getting Started Registration Checklist

**The CBIC is the official information source for bidders.** Suppliers are encouraged to call the CBIC customer service center toll-free at 877-577-5331 between 9 a.m. and 7 p.m. prevailing Eastern Time, Monday through Friday. Hours are extended to 9 p.m. prevailing Eastern Time during the last two weeks of the registration and bidding windows.

# MLN Connects® Provider eNews – October 22, 2015

MLN Connects® Provider eNews for October 22, 2015

View this edition as a PDF

## In This Edition:

**ICD-10**

- Learn How to Assign an ICD-10-CM Diagnosis Code with MLN Connects Videos
- Video Slideshow from August 27 MLN Connects Call Available
- 5 Ways to Check Your Claim Status
- Contact List for ICD-10 Questions

**MLN Connects® National Provider Calls and Events**

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call – Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

**Other CMS Events**

- EHR Incentive Programs: Recording from Final Rule Webinar Available

**Announcements**

- HHS Awards more than $240 Million to Expand the Primary Care Workforce
- HHS Awards up to $22.9 Million in Planning Grants for Certified Community Behavioral Health Clinics
- 2016 Value Modifier: Informal Review Request Period Open through November 9
- 2016 PQRS Payment Adjustment: Informal Review Request Period Open through November 9
- IRF Quality Reporting Program Data Submission Deadline: November 15
- LTCH Quality Reporting Program Data Submission Deadline: November 15
- MACRA Request for Information: Comments Accepted through November 17
- Dialysis Facility Compare: Submit your Comments through December 4
- New Survey Process for Duodenoscopes/ Endoscopes/ Reusable Medical Devices
- Hospice Quality Reporting Program: New Training Modules Available

**Claims, Pricers, and Codes**

- Mass Adjustments of IRF PPS Claims that Require a Special Wage Index

**Medicare Learning Network® Educational Products**

- "Infection Control: Environmental Safety" Web-Based Training Course – Released
- "Infection Control: Injection Safety" Web-Based Training Course – Released
- "PECOS for Provider and Supplier Organizations" Fact Sheet – Revised

# MLN Connects® Provider eNews Special Edition – October 22, 2015

## DMEPOS Fee Schedule DME and PEN Text File Formats – Revised

CMS recently released revised Public Use File (PUF) formats for the CY 2016 Durable Medical Equipment Prosthetics Orthotics Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) fee schedules. Revised 2016 Durable Medical Equipment (DME) and PEN text file formats are now available. Visit the Durable Medical Equipment Center web page for more information.

# MLN Connects® Provider eNews – October 29, 2015

MLN Connects® Provider eNews for October 29, 2015

View this edition as a PDF

## In This Edition:

**Editor's Note**

If you order or refer items or services for Medicare beneficiaries and do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. See the revised MLN Matters® Special Edition Article #SE1305. Also, see the revised MLN Matters Special Edition Article #SE1434 on provider enrollment requirements for writing prescriptions for Medicare Part D drugs. Learn how to enroll to order/refer or prescribe Part D drugs using the 855O and more.

**ICD-10**

- Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims
- Get ICD-10 Answers in One Place

**MLN Connects® National Provider Calls and Events**

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call – Register Now
- National Partnership to Improve Dementia Care and QAPI Call – Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

**Other CMS Events**

- Webinar for Comparative Billing Report on Optometry Services
- Long-Term Care Hospital Quality Reporting Program Provider Training

**Announcements**

- October is National Breast Cancer Awareness Month
- Protect Your Patients against Influenza and Pneumonia
- Hospital Value-Based Purchasing Program: FY 2016 Results
- DMEPOS Fee Schedule DME and PEN Text File Formats – Revised
- Antipsychotic Drug use in Nursing Homes: Trend Update
- EHR Incentive Programs: New Public Health Reporting FAQ

**Claims, Pricers, and Codes**

- Claims Processing Issue for non-Pneumococcal and Influenza Vaccines
- Correction of Mammography Claims
- October 2015 OPPS Pricer File Update

**Medicare Learning Network® Educational Products**

- "Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" MLN Matters Article – Revised
- "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A HHA Claims" MLN Matters Article – Revised
- New Medicare Learning Network Educational Web Guides Fast Fact

# MLN Connects® Provider eNews – November 5, 2015

MLN Connects® Provider eNews for November 05, 2015

View this edition as a PDF

## In This Edition:

**MLN Connects® National Provider Calls and Events**

- Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call – Last Chance to Register
- National Partnership to Improve Dementia Care and QAPI Call – Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call – Registration Now Open
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call – Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

**Announcements**

- Physician Fee Schedule: Policy and Payment Changes for CY 2016
- Hospital Outpatient and ASC: Policy and Payment Changes for CY 2016
- ESRD Facilities: Policies and Payment Rates for CY 2016
- HHAs: Payment Changes for CY 2016
- Discharge Planning Proposed Rule Focuses on Patient Preferences
- Final Waivers in Connection with the Shared Savings Program
- DMEPOS Competitive Bidding Round 1 2017: Covered Document Review Date November 16
- Physician Compare Preview Period Extended to November 16
- 2016 Value Modifier: Informal Review Deadline Extended to November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Extended to November 23
- Part D Prescribers Must Enroll in Medicare: Submit Your Application by January 1
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements?
- CMS to Release a Comparative Billing Report on Physical Therapy in November
- November is Home Care and Hospice Month
- Each Office Visit is an Opportunity to Recommend Influenza Vaccination
- Find Information on Medicare-Covered Preventive Services

**Claims, Pricers, and Codes**

- Colorectal Cancer Screening Claims Processing Issue
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 HH PPS PC Pricer Update Available

**Medicare Learning Network® Educational Products**

- Medicare Learning Network Catalog: November 2015 Version Available
- "ICD-10-CM Diagnosis Codes for Bone Mass Measurement" MLN Matters Article – Released
- "Medicare FFS Claims Processing Guidance for Implementing ICD-10" MLN Matters Article – Revised
- Medicare Learning Network Products Available in Electronic Publication Format

## MLN Connects® Provider eNews – November 12, 2015

MLN Connects® Provider eNews for November 12, 2015

View this edition as a PDF

### In This Edition:

**MLN Connects® Events**

- National Partnership to Improve Dementia Care and QAPI Call – Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call – Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call – Register Now

**Other CMS Events**

- LTCH Quality Reporting Program: In-Person Provider Training in Baltimore, MD

**Announcements**

- Three DMEPOS Competitive Bidding Reminders for Round 1 2017
- EHR Incentive Programs Stage 3 Final Rule: Submit Comments by December 15
- New FAQs on Participation in EHR Incentive Programs
- CMS Seeking Comment on MACRA Episode Groups by February 15
- Raising Awareness of Diabetes in November

**Claims, Pricers, and Codes**

- Pap Smear and PET Scan Claims Editing Incorrectly
- Additional Logic Applied to MDC 14

**Medicare Learning Network® Publications**

- Selecting Home Health Claims for Probe and Educate Review MLN Matters® Article – Released
- Clinical Laboratory Improvement Amendments Fact Sheet – Revised
- Inpatient Psychiatric Facility Prospective Payment System Fact Sheet – Revised
- Products Available in an Electronic Publication Format

## MLN Connects® Provider eNews – November 19, 2015

MLN Connects® Provider eNews for November 19, 2015

View this edition as a PDF

### In This Edition:

**MLN Connects® Events**

- National Partnership to Improve Dementia Care and QAPI Call – Register Now
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call – Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call – Register Now

**Announcements**

- Registration for DMEPOS Competitive Bidding Round 1 2017 Closes November 20
- CMS Awards Partnership-Driven Special Innovation Projects to QIN-QIOs
- Reducing Improper Payment: A Collaborative Effort
- Comprehensive Care for Joint Replacement Model
- Revised 2014 Annual QRURs Available

- 2016 Value Modifier Informal Review Deadline Ends November 23
- 2016 PQRS Payment Adjustment: Informal Review Deadline Ends November 23
- Comments on Discharge to Community Quality Measure due November 23
- Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements? – Updated
- EHR Incentive Programs: New Public Health Reporting FAQs
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

**Claims, Pricers, and Codes**

- ICD-10 Transition: Clarifications about NCDs and LCDs
- CY 2013 Referring Provider DMEPOS Data – Updated

**Medicare Learning Network® Publications**

- Complying with Documentation Requirements for Laboratory Services Fact Sheet – New
- Skilled Nursing Facility Prospective Payment System Booklet – Revised
- Product Available in an Electronic Publication Format

## MLN Connects® Provider eNews Special Edition – November 23, 2015

### Release of the 2016 DMEPOS Fee Schedules

On November 23, 2015, CMS announced the release of the 2016 Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule amounts that include adjusted fees based on DMEPOS Competitive Bidding Program information. For more information on the DMEPOS and Parenteral and Enteral Nutrition(PEN) public use files, visit the Durable Medical Equipment Center webpage.

## MLN Connects® Provider eNews – November 25, 2015

MLN Connects® Provider eNews for November 25, 2015

View this edition as a PDF

### In This Edition:

**MLN Connects® Events**

- National Partnership to Improve Dementia Care and QAPI Call – Last Chance to Register
- Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call – Register Now
- ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call – Register Now
- ESRD QIP: Payment Year 2019 Final Rule Call – Registration Now Open
- New MLN Connects National Provider Call Audio Recording and Transcript

**Announcements**

- Release of the 2016 DMEPOS Fee Schedules
- December 1 is World AIDS Day: The Time to Act is Now
- Comments on Tobacco Treatment Measures due December 4
- 2016 Value Modifier Informal Review Deadline Extended to December 16
- 2016 PQRS Payment Adjustment: Informal Review Deadline Extended to December 16

**Claims, Pricers, and Codes**

- Smoking Cessation Claims Editing Incorrectly
- Home Health Billing Codes Changing January 1

## FYI

**Medicare Learning Network® Publications**

- Clarification of Patient Discharge Status Codes and Hospital Transfer Policies MLN Matters® Article — Revised
- Verify Your Profile Information in the Learning Management/Product Ordering System
- New Educational Web Guides Fast Fact

## APPEALS

### Telephone Reopenings: Resources for Success

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

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

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

| How do I request a Telephone Reopening? | To request a reopening via telephone, call 1-888-826-5708. |
|---|---|
| **What are the hours for Telephone Reopenings?** | Monday through Friday<br>8 a.m. - 4:30 p.m. CT<br>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.<br>• National Provider Identifier (NPI)<br>• Provider Transaction Access Number (PTAN)<br>• Last five digit of Tax ID Number (TIN)<br>• Supplier name<br>• Beneficiary's Health Insurance Claim Number (HICN)<br>• Beneficiary's first and last name<br>• Beneficiary's date of birth<br>• Date of service (DOS)<br>• Healthcare Common Procedure Coding System (HCPCS) code(s) in question<br>• Corrective action to be taken<br><br>**Note:** Claims with remark code MA130 can never be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted. |

| How do I request a Telephone Reopening? | To request a reopening via telephone, call 1-888-826-5708. |
|---|---|
| **What may I request as a Telephone Reopening?** | The following is a list of clerical errors and omissions that may be completed as a Telephone Reopening.<br>**Note:** This list is not all-inclusive.<br>• Diagnosis code changes or additions<br>• Date of Service (DOS) changes<br>• HCPCS code changes<br>• Certain modifier changes or additions (not an all-inclusive list)<br>  • KH<br>  • KI<br>  • KJ<br>  • RR<br>  • NU<br>  • AU<br>  • KL<br>  • RT<br>  • LT<br>**Note:** If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation. |

| How do I request a Telephone Reopening? | To request a reopening via telephone, call 1-888-826-5708. |
|---|---|
| **What is not accepted as a Telephone Reopening?** | The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation.<br>• Overutilization denials that require supporting medical records<br>• Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013, titled "Denied Claims Requiring CMN/DIF Must be Resubmitted, Rather than Reopened"<br>• Oxygen break in service (BIS) issues<br>• Some manual wheelchairs and all power mobility devices (PMDs) – HCPCS K0005 and higher<br>• Overpayments or reductions in payment<br>• Medicare Secondary Payer (MSP) issues<br>• Claims denied for timely filing<br>• Reopenings past one year from the initial determination<br>• Complex Medical Reviews or Additional Documentation Requests<br>• Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues<br>• Repair and labor claims<br>• Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing<br>• The following modifier changes or additions:<br>  • A1 through A9<br>  • K0 through K4<br>  • GA<br>  • GY<br>  • GZ<br>  • KX<br>  • EY<br>  • KG<br>  • RA<br>  • RB<br>  • RP<br>• Certain HCPCS codes (not all-inclusive list)<br>  • A4450 through A4452<br>  • E0194<br>  • E0748<br>  • E1028<br>  • J1559<br>  • J1561<br>  • J1562<br>  • K0108<br>  • K0462 |

| How do I request a Telephone Reopening? | To request a reopening via telephone, call 1-888-826-5708. |
|---|---|
| **What do I do when I have a large amount of corrections?** | If a supplier has more than 50 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information and provide further direction how to submit the request.<br>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<br>• Appeals Section on the Noridian DME website<br>• 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. |

## 2016 Federal Court Review Amount in Controversy

The amount that must remain in controversy for review in Federal District Court requested on or before December 31, 2015, is $1,460. This amount will increase to $1,500 for appeals to Federal District Court filed on or after January 1, 2016.

## C2C Solutions, Inc. Changes Name to C2C Innovative Solutions, Inc.

The Qualified Independent Contractor (QIC), C2C Solutions Inc., is now doing business as C2C Innovative Solutions, Inc. Contact information remains the same.

## Denied Claims Requiring CMN/DIF – Reopenings

Effective November 23, 2015, Written Reopenings is no longer able to load DME Information Forms (DIFs) if the claim denied for no DIF. Written Reopenings is still able to load a Certificate of Medical Necessity (CMN). This is due to the complexity of the information contained on the Nutrition and External Infusion Pump DIFs.

Telephone Reopenings also does not load CMN or DIFs if the claim denied for no CMN/DIF.

Suppliers usually see the following claim adjustment reason code (CARC) and remittance advice remark code (RARC) combinations on the remittance advice for missing CMN/DIF denials:

No CMN/DIF: CARC 173 and RARC M60

No recertification or revised CMN/DIF: CARC 176 and RARC N170

In order to correct the situation when a CMN/DIF was needed, but not submitted, and the claim denied for this reason, the supplier has multiple options:

1. Resubmit the claim with the CMN/DIF
2. File a Redetermination to load the DIF (and submit all supporting documentation)
3. Complete the Written Reopening form and submit along with the CMN (no longer an option for DIFs)

Once the CMN/DIF is loaded, suppliers are able to request a reopening via either a Written Reopening or Telephone Reopening for claims that initially denied for no CMN/DIF.

DMEPOS requiring a CMN/DIF include Oxygen, Pneumatic Compression Devices, Osteogenesis Stimulators, Transcutaneous Electrical Nerve Stimulators (TENS), External Infusion Pumps, Enteral and Parenteral Nutrition, and Seat Life Mechanisms.

**Note:** These changes do not affect Appeal Rights.

## BILLING

# DME on Demand – Front End Edits: Claim Rejections

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

This session will include:

- Electronic Claims
- Common Electronic Data Interchange (CEDI)
- 277CA Report
- Resources

### Viewing Presentation

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

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

## CERT

# 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.

# Claim Status Category and Claim Status Codes Update

**MLN Matters® Number: MM9276**
**Related Change Request (CR) #: CR 9276**
**Related CR Release Date: August 28, 2015**
**Effective Date: January 1, 2016**
**Related CR Transmittal #: R3344CP**
**Implementation Date: January 4, 2016**

## Provider Types Affected

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

## What You Need to Know

Change Request (CR) 9276 informs MACs about the changes to the Claim Status Category and Claim Status Codes.

## 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 Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response transaction standards adopted under HIPAA for electronically submitting health care claims status requests and responses. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 transactions to report claim status.

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

All code changes approved during the September/October 2015 committee meeting will be posted on those sites on or about November 1, 2015. MACs must complete entry of all applicable code text changes, add new codes, and terminate use of deactivated codes by the implementation date of CR9276.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9276.

## Additional Information

The official instruction, CR9276 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3344CP.pdf on the CMS website.

# HCPCS Codes for SNF CB – 2016 Annual Update

**MLN Matters® Number: MM9340**
**Related Change Request (CR) #: CR 9340**
**Related CR Release Date: September 11, 2015**
**Effective Date: January 1, 2016**
**Related CR Transmittal #: R3349CP**
**Implementation Date: January 4, 2016**

## Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (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) 9340 could impact your payments. CR 9340 provides the 2016 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and explains how the updates affect edits in Medicare claims processing systems. By the first week in December 2015, 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 on the Centers for Medicare & Medicaid Services (CMS) website; and become effective on January 1, 2016.

It is important and necessary for the provider community to 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 "Medicare Claims Processing Manual," Chapter 6 (SNF Inpatient Part A Billing and SNF Consolidated Billing), Sections 20.6 and 110.4.1. You may view this manual at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf on the CMS website.

## Additional Information

The official instruction, CR 9340 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3349CP.pdf on the CMS website.

# Claim Status Category and Claim Status Code Update

**MLN Matters® Number: MM9427**
**Related Change Request (CR) #: CR 9427**
**Related CR Release Date: November 20, 2015**
**Effective Date: April 1, 2016**
**Related CR Transmittal #: R3413CP**
**Implementation Date: April 4, 2016**

## Provider Types Affected

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

## What You Need to Know

Change Request (CR) 9427 informs MACs about the changes to Claim Status Category and Claim Status Codes.

## 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 (NCMC) in the Accredited Standards Committee (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 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 has decided to allow the industry 6 months for implementation of newly added or changed codes.

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

All code changes approved during the January 2016 committee meeting shall be posted on these sites on or about February 1, 2016. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes, by the implementation date of CR9427.

These code changes are to be used in editing of all ASC X12 276 transactions processed on or after the date of implementation and to be reflected in the ASC X12 277 transactions issued on and after the date of implementation of CR9427.

CMS and the 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. These contractors must use valid Claim Status Category Codes and Claim Status Codes when sending ASC X12 277 Health Care Claim Status Responses and 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, CR9427, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3413CP.pdf on the CMS website.

# PROSE® Device – Correct Coding

## Joint DME MAC and PDAC Article

Recently the DME MACs have received questions about the proper coding of the PROSE® device (BostonSight). PROSE® devices are designed to rest on the sclera or white part of the eye and are used to treat ocular surfaces diseases, including some types of "dry eye". This article discusses the correct coding of the PROSE® device.

For Medicare billing purposes correct HCPCS coding for this item is determined based upon the condition(s) being treated. When the PROSE® device is used as a treatment for certain types of dry eye (see below) the device must be coded as a scleral shell with HCPCS code V2627 (scleral cover shell).

Coverage criteria for scleral shells (V2627) is outlined in the Centers for Medicare & Medicaid Services National Coverage Determination 80.5 (Internet Only Manual 100-3, Chapter 1, Part 1, §80.5). Coverage for V2627 is limited to two conditions:

- Treatment of an eye rendered sightless and shrunken by inflammatory disease; and,
- Treatment of "dry eye" where the PROSE® device serves as a substitute for the function of the diseased lacrimal gland.

When the PROSE® device is used for **any conditions** other than those listed above, the device must be coded with HCPCS code V2531 (contact lens, scleral, gas permeable, per lens) and is subject to the Medicare refractive lens statutory coverage exclusion.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 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 – Diathermy and Biofeedback Devices

## Joint DME MAC Publication

Recently HCPCS coding verification reviews have been received for both diathermy and biofeedback devices used as part of inpatient or outpatient facility therapy but that are subsequently given to the beneficiary for use in the home. These items do not meet the payment requirements to be reimbursed as durable medical equipment (DME).

Diathermy and biofeedback therapies are addressed separately by National Coverage Determinations; NCD 150.5 for "Diathermy Treatment" and NCD 30.1 for "Biofeedback Therapy". Both of these services are coded using Current Procedural Terminology (CPT) Codes. The equipment used in association with the provision of these services falls under the jurisdiction of the Medicare A/B Medicare Administrative Contractor (MAC). All diathermy and biofeedback devices are considered not separately billable to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) under the DME Benefit.

The Pricing, Data Analysis and Coding Contractor (PDAC) will assign the coding determination, "NO HCPCS CODE ASSIGNED" to diathermy and biofeedback devices submitted for review. A comment stating "NOT BILLABLE TO THE DME MACS" will be added to each diathermy and biofeedback device posted on the DMECS Product Classification List.

Devices not reviewed or not listed on DMECS must not be billed to the DME MAC. Claims submitted to the DME MACs for diathermy and biofeedback devices will be denied as wrong jurisdiction.

Manufacturers, distributors and suppliers should consult the Medicare A/B MAC contractor for correct billing of these devices.

For questions about coding verification reviews and correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 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/.

## Correct Coding – Buzzy®

### Joint DME MAC Publication

The Buzzy® (MMJ Labs) is a palm-sized vibrating bee with a removable ice pack and center slot for an optional tourniquet. Per the manufacturer, when placed proximal to a painful procedure, the combination of cold and vibration block transmission of sharp pain. The device also buzzes like a bee, which provides an auditory distraction. The Buzzy Deluxe Kit includes: neoprene Cold-to-Go Tote, Buzzy® and Bee Stractors™ (distraction device), a Velcro strap, 2 AAA batteries, a set of Blue Gel Wings and two White Ice Wings for longer procedures. Frozen inserts are also included to keep the bag and the frozen wings cold. Buzzy's housing is composed of durable GE Lexan polycarbonate material and may be cleaned with germicidal disposable wipes.

Claims for The Buzzy® billed to the DME MAC must be coded with HCPCS code A9270 (Noncovered item or service) and will be denied as statutorily non-covered (no benefit).

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 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/.

## Correct Coding – P-stim® Device

Recently the DME MAC contractors have received inquiries about the P-stim® auricular stimulation device (Biegler GmbH). The P-stim® is a miniaturized electro-acupuncture device for use in the practice of acupuncture by qualified practitioners of acupuncture. It provides auriculo-point stimulation treatment over several days. This item is not reimbursable by Medicare. Claims submitted to the DME MACs for the P-stim® device must be coded A9270 (Noncovered item or service).

For questions about coding verification reviews and correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 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/.

## Correct Coding – TOBI® Podhaler™

### Joint DME MAC Publication

The TOBI® Podhaler™ (Novartis) is a disposable, hand-held medication dispenser used for the inhalation of tobramycin. This device is not a hand-held nebulizer with a pneumatic compressor and thus is not eligible for reimbursement under the Medicare Durable Medical Equipment Benefit. The TOBI® Podhaler™ is provided as a complete system that includes both the inhaler and tobramycin capsules. Claims for the TOBI® Podhaler™ billed to the DME MAC must be coded with HCPCS code A9270 (Noncovered item or service) and will be denied as statutorily non-covered (no benefit).

HCPCS Code J7682 (Tobramycin, Inhalation Solution, FDA-Approved Final Product, Non-Compounded, Unit Dose Form, Administered Through DME, Per 300 Milligrams) must not be used to bill separately for the tobramycin capsules provided for use in a TOBI® Podhaler™. Separate billing for the TOBI® Podhaler™ device and tobramycin capsules will be denied as unbundling.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 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/.

## Correct Coding – Tracheostomy Tubes

### Joint DME MAC Publication

Recently the PDAC and DME MACs have received questions about the proper coding of "customized" tracheostomy tubes. Manufacturers often describe customized tracheostomy tubes as those having a non-standard shaft length or diameter. Variations in construction materials, cuff type, etc. are also sometimes used by manufacturers to define a non-standard product.

## CODING

**The HCPCS codes for tracheostomy tubes are:**

**A7520** – TRACHEOSTOMY/LARYNGECTOMY TUBE NON-CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH

**A7521** – TRACHEOSTOMY/LARYNGECTOMY TUBE CUFFED, POLYVINYLCHLORIDE (PVC), SILICONE OR EQUAL, EACH

Both codes are all-inclusive. All variations in tracheostomy tube construction such as dimensions, materials, cuffs, connectors etc., including all variation often classified by tube manufacturers as customized tracheostomy tubes are included in HCPCS codes A7520 and A7521.

Miscellaneous or NOC (not otherwise classified) codes such as E1399 (DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS) or A9999 (MISCELLANEOUS DME SUPPLY OR ACCESSORY, NOT OTHERWISE SPECIFIED) must not be used to bill Medicare for any tracheostomy tube. Use of a miscellaneous code to bill Medicare for any tracheostomy tubes is incorrect coding.

For questions about correct coding, contact the Pricing, Data Analysis and Coding (PDAC) Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4 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/.

## COMPETITIVE BIDDING

### DMEPOS CBP – January 2016 Quarterly Update

**MLN Matters® Number: MM9383**
**Related Change Request (CR) #: CR 9383**
**Related CR Release Date: October 16, 2015**
**Effective Date: January 1, 2016**
**Related CR Transmittal #: R3377CP**
**Implementation Date: January 4, 2016**

#### Provider Types Affected

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

#### What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9383 to provide the DMEPOS Competitive Bidding Program (CBP) January 2016 quarterly update. CR9383 provides specific instructions for the DME MACs in implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files.

#### Background

The DMEPOS Competitive Bidding Program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The statute requires that Medicare replace the current fee schedule payment methodology for selected Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items with a competitive bid process. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services.

Under the program, a competition among suppliers who operate in a particular competitive bidding area is conducted. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process and required documents are mailed. Bids are evaluated based on the supplier's eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

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

### Additional Information

The official instruction, CR9383, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3377CP.pdf on the CMS website.

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

There are a number of products in the MLN Catalog of Products that describe the various aspects of the DMEPOS program. These fact sheets and booklets provide information for pharmacies, ways to pay for medical equipment, billing procedures for upgrades, repairs and replacements of equipment, and more.



## MSP Policy and Procedures Regarding ORM

**MLN Matters® Number: MM8984**
**Related Change Request (CR) #: CR 8984**
**Related CR Release Date: September 18, 2015**
**Effective Date: October 1, 2015**
**Related CR Transmittal #: R114MSP and R3358CP**
**Implementation Date: October 5, 2015**

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 8984, through which the Centers for Medicare & Medicaid Services (CMS) outlines its Medicare claims processing requirements specific to Ongoing Responsibility for Medicals (ORM) for liability insurance (including self-insurance), no-fault insurance, and workers' compensation in Medicare Secondary Payer (MSP) situations.

Liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans are required to report settlements, judgments, awards, or other payments to CMS, including ORM. The purpose of CR 8984 is to educate and instruct providers and the MACs about the policy and procedures related to ORM reporting. Make sure that your billing staffs are aware of these changes.

MSP claims impacted by employer Group Health Plan coverage will be not affected by this change.

### Background

Pursuant to section 1862(b)(8) of the Social Security Act, "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) are required to report settlements, judgments, awards or other payments involving individuals who are or were Medicare beneficiaries to CMS. The applicable plan is the "Responsible Reporting Entity" (RRE) for this process. The required reporting includes instances where the RRE has ORM associated with specified medical conditions. This information is collected to determine primary claims payment responsibility. Examples of ORM include, but are not limited to, a no-fault insurer agreeing to pay medical bills submitted to it until the policy in question is exhausted or a workers' compensation plan being required under a particular state law to pay associated medical costs until there is a formal decision on a pending workers' compensation claim.

The RRE may assume responsibility for ORM for one or more alleged injuries/illnesses without assuming ORM for all alleged injuries/illnesses in an individual's liability insurance (including self-insurance), no-fault insurance, or workers' compensation claim. For example, if an individual is alleging both a broken leg and a back injury, the RRE might assume responsibility for the broken leg but continue to dispute the alleged back injury.

When ORM ends (for example, a policy limit is reached or a settlement occurs which terminates the RRE responsibility to pay on an ongoing basis), the RRE reports an ORM Termination Date, and this information is uploaded to Medicare's Common Working File (CWF) by the Benefit Coordination & Recovery Center (BCRC).

An ORM report is not a guarantee that medicals will be paid indefinitely or through a particular date.

Pursuant to section 1862(b)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)(ii)), Medicare is precluded from making payment where payment "has been made, or can reasonably be expected to be made…" under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter, referred to as Non-Group Health Plan (NGHP). Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

CR 8984 includes modifications to Medicare systems to automate the fact that ORM responsibility is assumed, exists, or did exist for a particular period of time. All MACs shall reference the modified CWF MSPD screen to determine if ORM exists in association with MSPD (No-Fault – 14), E (Workers Compensation -15), and L (Liability - 47) records for the date(s) of service at issue. When claims are processed, Medicare will compare the diagnosis code(s) on the claim with the diagnosis code(s) associated with the ORM record. All MACs shall deny claims where the ORM indicator is present for the period covered by the claim and the diagnosis code(s) match(es) (or match(ed)) within the family of diagnosis codes). As stated, documentation from the RRE that the ORM terminated or is otherwise exhausted may require that the previously denied claim be reprocessed. (Any claim will also process for a potential Workers' Compensation Medicare Set-Aside (WCMSA) denial where there is no denial based upon the ORM indicator.)

As stated above, MACs shall deny payment for claim lines with open ORM for the date of service for the associated diagnosis code(s) or family of diagnosis codes. The prompt payment rules do not override this requirement; therefore, a conditional payment cannot be made to providers when ORM exists for the item or service in question. However, as stated, the reported ORM is not a guarantee that medicals will be paid indefinitely or through a particular date. Consequently, if a claim is denied on the basis of ORM and the MAC receives information that the policy limit has been appropriately exhausted -- even though the claim in question is for services prior to the ORM termination date -- the claim may be paid if it is otherwise covered and reimbursable. This type of situation could occur where there has been a delay in billing to the RRE or where part of a group of claims submitted to the RRE was sufficient to exhaust the policy.

When Medicare denies claims due to the ORM indicator, the remittance advice for the denied claim will reflect one of the following Claims Adjustment Reason Codes (CARC) and Remittance Advice Remarks Codes (RARC):

**CARC 19** – "This is a work-related injury/illness and thus the liability of the Workers' Compensation Carrier." Also, RARC N728 – "A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis"— will appear. (NOTE: To be used with Group Code PR.)

**CARC 20** – "This injury/illness is covered by the liability carrier." Also, RARC N725 – "A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" — will appear. (NOTE: To be used with Group Code PR.)

**CARC 21** – "This injury/illness is the liability of the no-fault carrier." Also, RARC N727 – "A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis" — will appear. (NOTE: To be used with Group Code PR.)

However, Medicare payment will be made for services if the following codes and conditions are met (assumption: primary payer did not pay for an acceptable reason; for example, benefits appropriately exhausted, or benefits no longer covered due to state imposed limits, etc.):

- Any of the following CARCs are found on the ORM claim: 26, 27, 31, 32, 35, 49, 50, 51, 53, 55, 56, 60, 96, 119, 149, 166, 167, 170, 184, 200, 201, 204, 242, 256, B1 (if a Medicare covered visit), B14; and
- The service is covered and otherwise reimbursable by Medicare.

### Additional Information

**Important:** Providers, physicians, and other suppliers should know that CMS is implementing use of the ORM indicator on a gradual basis, beginning in January 2016. Appeal rights apply to all claims denied due to ORM as part of MSP claims processing.

The official instruction, CR 8984, was issued to your MAC regarding this change via two transmittals. The first transmittal is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R114MSP.pdf and the second transmittal is at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3358CP.pdf on the CMS website.

You may find further information about the mandatory reporting required by liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans by going to http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html on the CMS website.

## BMD Response to Comments

The public comment period for the draft local coverage determination for Bowel Management Devices (BMD) closed on August 31, 2015. A public meeting was held on August 26, 2015.

### Comments – Renew® Anal Insert

1. The draft LCD did not take into account the latest published, peer-reviewed literature on the safety and efficacy of the device (Lukacz, et.al. Dis Rectum Colon 2015;58:892-898).

   **Response:** There are only two articles published in the peer-reviewed literature evaluating the safety and efficacy of the Renew® Anal Insert device. The Lukacz article cited by the commenter has several shortcomings as pointed out by the authors:

   - Use of a nonvalidated assessment scale
   - Non-randomized
   - No control comparison group
   - Non-blinded

   In addition to the above points, the Medical Directors also note the following issues:

   - Short treatment time (12 weeks)
   - "Satisfaction" with device only assessed and reported in those completing 12 week trial thus introducing bias by not counting those that dropped out due to dissatisfaction with the device
   - 25% withdrawal rate from study
   - Dropout rate higher for Medicare-age population
   - Average age of those withdrawing – 74.3 (range 55.2 – 85.2)
   - Average age of those completing – 67.2 (range 33.9 – 88.9)
   - 49% self-reported effectiveness rate
   - Study development, implementation, data collection and data analysis funded by manufacturer
   - All authors of the study were paid consultants to manufacturer

   At this time, based on the paucity of literature demonstrating the effectiveness of the Renew® Anal Insert device, the Medical Directors will maintain the current not reasonable and necessary coverage statement.

2. Rectal inserts are not investigational or experimental.

   **Response:** The Medical Directors agree; however, as noted above, the strength of the peer-reviewed literature does not support Medicare coverage at this time.

3. CMS acknowledges the similarity between urethral inserts and rectal inserts and should afford similar coverage.

   Response: Coverage of one type of device by Medicare does not confer automatic coverage of another device. The strength of the peer-reviewed literature does not support Medicare coverage of the Renew® Anal Insert device at this time.

### Comments – Peristeen® Transanal Irrigation (TAI) System

1. The proposed draft uses an incorrect and incomplete definition of "prosthetic device" as applied to the Peristeen® Transanal Irrigation (TAI) System. The Peristeen® Transanal Irrigation (TAI) System should be afforded coverage under the Prosthetic Devices benefit category.

   **Response:** The Medical Directors disagree. The Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Workgroup has determined that the Peristeen® Transanal Irrigation (TAI) System is not a prosthetic device. Moreover, as noted in the related Policy Article for the draft LCD, it does not meet the definition of durable medical equipment.

   The CMS HCPCS Workgroup held a public meeting on May 28, 2014 to hear comments on the applications for new 2015 HCPCS codes. The CMS HCPCS Workgroup is comprised of members from commercial insurance plans, the Veteran's Administration, CMS and state Medicaid agencies. A summary of the meeting preliminary decisions is available on the CMS.gov website at http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2014-05-28-Supply-Summary.pdf.

   The CMS HCPCS Workgroup determined that the preliminary coding determination associated with this request indicated that existing code A4458 'Enema bag with tubing, reusable' adequately describes the product, and the preliminary payment determination associated with this request indicated that the payment rules associated with the existing code apply to this product. Pricing = 00.

   In fecal incontinence, there is a malfunction of the anal sphincter. Based on a review of the Peristeen® product, we do not believe that it replaces the function or structure of the anal sphincter. Similar to other enema systems, it helps with defecation by increasing the fluid in the bowel. The Medical Directors therefore believe that the HCPCS Workgroup determination of benefit category and the pricing indicator of 00 for code A4459 is correct.



## Standard Documentation Language for Local Coverage Determinations and Related Policy Articles – Revised

### Joint DME MAC Publication

**Note:** This is a revision to the previous article published in October 2014. This version clarifies the requirements for dispensing orders and detailed written orders with respect to start dates and the dates required on orders.

This information will be added to future revisions of the LCDs.

Many errors reported in DME MAC MR Reviews and CERT Audits arise from problems associated with submitted documentation; consequently, the DME MACs have created a standardized language for use in Local Coverage Determinations and related Policy Articles. Standardized language first appeared in 2012 and with subsequent changes in CMS and DME MAC program instructions, is being revised with this publication. The updated language will be inserted in the applicable LCDs and related PAs upcoming revisions to these policies.

The standard sections are written in a modular format to allow each policy to contain information relevant to that policy while not including material that does not apply. This article provides a complete listing of all of the documentation requirement modules. All modules may not be used in every LCD. For example, the CMN sections would not be included in the DOCUMENTATION REQUIREMENTS section of an LCD for an item that does not require a CMN.

***IMPORTANT***

Many policies contain coverage and documentation requirements that are unique to that specific policy. Such unique information is not included in this article. It is important that suppliers review the actual LCD to be sure to have all of the relevant information necessary applicable to the item(s) provided.

In several places you will see "placeholders" like "XXX" or "###". Information specific to the policy will be inserted in these spots. Occasionally you may also see "Editor Note" comments. These notes are used to indicate where optional sections may be inserted, when applicable and formatting information.

**Standard Language**

## LCD

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

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act §1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee for Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.

**DWO Verbiage**

For an item to be covered by Medicare, a detailed written order (DWO) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed DWO, the item will be denied as not reasonable and necessary.

**ACA WOPD (Editor Note: Insert after DWO section)**

For some items in this policy to be covered by Medicare, a written order prior to delivery (WOPD) is required. Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

**REFILL REQUIREMENTS (Editor Note: Use for those LCDs with continuous supplies)**

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-08, Chapter 5, Section 5.2.6).

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

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

## DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

## PRESCRIPTION (ORDER) REQUIREMENTS

### GENERAL (PIM 5.2.1)

All items billed to Medicare require a prescription. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items dispensed and/or billed that do not meet these prescription requirements and those below must be submitted with an EY modifier added to each affected HCPCS code.

### DISPENSING ORDERS (PIM 5.2.2)

Equipment and supplies may be delivered upon receipt of a dispensing order except for those items that require a written order prior to delivery. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item
- Beneficiary's name
- Prescribing physician's name
- Date of the order
- Physician signature (if a written order) or supplier signature (if verbal order)

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

In some cases, the physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed prescription with a correctly determined prescription date, an item may be shipped or delivered on or after the prescription date (except for items that require written orders prior to delivery).

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The dispensing order must be available upon request.

For items that are provided based on a dispensing order, the supplier must obtain a detailed written order before submitting a claim.

### ACA 6407 (Prescription Requirements, prior to DWO)

**WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1)**

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes specified in the table contained in the Policy Specific Documentation Requirements Section below. The supplier must have received a complete WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item. Refer the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about the statutory requirements associated with a WOPD.

**DETAILED WRITTEN ORDERS (PIM 5.2.3)**

A detailed written order (DWO) is required before billing. Someone other than the ordering physician may produce the DWO. However, the ordering physician must review the content and sign and date the document. It must contain:

- Beneficiary's name
- Physician's name
- Date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

For items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

For the "Date of the order" described above, use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders).

With respect to the date on the DWO/WOPD:

1. If the prescriber creates a complete and compliant DWO/WOPD, only a single date – the "order date" – is required. This order date may be the date that the prescriber signs the document (either wet signature or electronic signature)
2. If someone other than the prescriber (e.g., DME supplier) creates the DWO/WOPD then the prescription must be reviewed and, "…personally signed and dated…" by the prescriber. In this scenario two (2) dates are required: an "order date" and a prescriber-entered "signature date".

In some cases, the physician may specify a future start date for therapy that is different from the date of the order. This start date does not impact the date of service (DOS) entered on the claim, Medicare-required forms (e.g., CMN, DIF) or refill/delivery timelines. As long as the supplier has a properly completed prescription with a correctly determined prescription date, an item may be shipped or delivered on or after the prescription date (except for items that require written orders prior to delivery).

Frequency of use information on orders must contain detailed instructions for use and specific amounts to be dispensed. Reimbursement shall be based on the specific utilization amount only. Orders that only state "PRN" or "as needed" utilization estimates for replacement frequency, use, or consumption are not acceptable. (PIM 5.9)

The detailed description in the written order may be either a narrative description or a brand name/model number.

Signature and date stamps are not allowed. Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

The DWO must be available upon request.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record. (PIM 5.2.3)

**WRITTEN ORDERS PRIOR TO DELIVERY (PIM 5.2.3.1) (Editor Note: Only for WOPD items)**

A detailed written order prior to delivery (WOPD) is required for XXX. The supplier must have received a WOPD that has been both signed and dated by the treating physician and meets the requirements for a DWO before dispensing the item.

## MEDICAL RECORD INFORMATION

**GENERAL (PIM 5.7 -5.9)**

The **Coverage Indications, Limitations and/or Medical Necessity** section of this LCD contains numerous reasonable and necessary (R&N) requirements. The **Non-Medical Necessity Coverage and Payment Rules** section of the related Policy Article contains numerous non-reasonable and necessary, benefit category and statutory requirements that must be met in order for payment to be justified. Suppliers are reminded that:

- Supplier-produced records, even if signed by the ordering physician, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.
- Templates and forms, including CMS Certificates of Medical Necessity, are subject to corroboration with information in the medical record.

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and CMNs. The medical record is not limited to physician's office records but may include records from hospitals, nursing facilities, home health agencies, other healthcare professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

**CONTINUED MEDICAL NEED**

For all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary's medical record must have been created prior to, or at the time of, the initial date of service (DOS) to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the DOS under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed CMN or DIF with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in the policy.

**CONTINUED USE**

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

Suppliers are responsible for monitoring utilization of DMEPOS rental items and supplies. No monitoring of purchased items or capped rental items that have converted to a purchase is required. Suppliers must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or supplier records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/ accessories and supplies
- Supplier records documenting the request for refill/replacement of supplies in compliance with the Refill Documentation Requirements (This is deemed to be sufficient to document continued use for the base item, as well)
- Supplier records documenting beneficiary confirmation of continued use of a rental item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified elsewhere in this policy.

**REFILL DOCUMENTATION (PIM 5.2.5-6) (Editor Note: Only for policies with items subject to refill requirements)**

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

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

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

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

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

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

**PROOF OF DELIVERY (PIM 4.26, 5.8)**

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. For medical review purposes, POD serves to assist in determining correct coding and billing information for claims submitted for Medicare reimbursement. Regardless of the method of delivery, the contractor must be able to determine from delivery documentation that the supplier properly coded the item(s), that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary.

Suppliers, their employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The signature and date the beneficiary or designee accepted delivery must be legible.

For the purpose of the delivery methods noted below, designee is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

Proof of delivery documentation must be available to the Medicare contractor on request. All services that do not have appropriate proof of delivery from the supplier will be denied and overpayments will be requested. Suppliers who consistently fail to provide documentation to support their services may be referred to the OIG for imposition of Civil Monetary Penalties or other administrative sanctions.

(Editor Note: Some LCDs only have 2 methods of delivery – Delete #3)

Suppliers are required to maintain POD documentation in their files. For items addressed in this policy there are three methods of delivery:

1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service
3. Delivery of items to a nursing facility on behalf of the beneficiary

## Method 1 – Direct Delivery to the Beneficiary by the Supplier

Suppliers may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee or the supplier. When the supplier's delivery documents have both a supplier-entered date and a beneficiary or beneficiary's designee signature date on the POD document, the beneficiary or beneficiary's designee-entered date is the date of service.

In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

## Method 2 – Delivery via Shipping or Delivery Service Directly to a Beneficiary

If the supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. An example of acceptable proof of delivery would include both the supplier's own detailed shipping invoice and the delivery service's tracking information. The supplier's record must be linked to the delivery service record by some clear method like the delivery service's package identification number or supplier's invoice number for the package sent to the beneficiary. The POD record must include:

- Beneficiary's name

- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

Suppliers may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD document must contain the information specified above.

### Method 3 – Delivery to Nursing Facility on Behalf of a Beneficiary

When a supplier delivers items directly to a nursing facility, the documentation described for Method 1 (see above) is required.

When a delivery service or mail order is used to deliver the item to a nursing facility, the documentation described for Method 2 (see above) is required.

Regardless the method of delivery, for those beneficiaries that are residents of a nursing facility, information from the nursing facility showing that the item(s) delivered for the beneficiary's use were actually provided to and used by the beneficiary must be available upon request.

#### EQUIPMENT RETAINED FROM A PRIOR PAYER

When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage plan) becomes eligible for the Medicare FFS program, the first Medicare claim for that item or service is considered a new initial Medicare claim for the item. Even if there is no change in the beneficiary's medical condition, the beneficiary must meet all coverage, coding and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility. To meet the POD requirements for a beneficiary transitioning to Medicare, the supplier:

1. Must obtain a new POD as described above under "Methods of Delivery" (whichever method is applicable); or,
2. Must obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), attesting that the supplier has examined the DMEPOS item, it is in good working order and that it meets Medicare requirements.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

## POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

#### AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to certain specified items in this policy. In this policy the specified items are:

These items require an in-person or face-to-face interaction between the beneficiary and their treating physician prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order is not sufficient to provide these items. A Written Order Prior to Delivery (WOPD) is required. Refer to the related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information about these statutory requirements.

## DOCUMENTATION

The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

**GENERAL**

**CERTIFICATE OF MEDICAL NECESSITY (PIM 5.3) (Editor Note: Only for items requiring CMN)**

A Certificate of Medical Necessity (CMN), which has been completed, signed, and dated by the treating physician, must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for the detailed written order if it contains the same information as required in a detailed written order. The CMN for XXX is CMS Form ### (DME form ###). In addition to the order information that the physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the order or the physician can enter the other details directly.

(Editor Note: Add specific DIF instructions as needed)

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

**DME INFORMATION FORM (PIM 5.3)**

(Editor Note: Only for items requiring a DIF)

A DME Information Form (DIF), which has been completed, signed, and dated by the supplier, must be kept on file and made available upon request. The DIF for XXX is CMS Form ### (DME form ###).

(Editor Note: Add specific DIF instructions as needed)

**REPAIR/REPLACEMENT (BPM Ch 15, §110.2)**

(Editor Note: Applies to all DMEPOS except artificial limbs)

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

1. The treating physician must document that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above).; and,
2. Either the treating physician or the supplier must document that the repair itself is reasonable and necessary.

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

**REPAIR/REPLACEMENT (BPM Ch 15, §120)**

(Editor Note: Only applies to Lower Limb Prostheses LCD)

Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

## DOCUMENTATION

Medicare payment may be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions if an ordering physician determines that the replacement device, or replacement part of such a device, is necessary. Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket) must be supported by a new physician's order and documentation supporting the reason for the replacement. The reason for replacement must be documented by the treating physician, either on the order or in the medical record, and must fall under one of the following:

1. A change in the physiological condition of the patient resulting in the need for a replacement. Examples include but are not limited to, changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes; or,
2. An irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or,
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request. It is recognized that there are situations where the reason for replacement includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive beneficiary weight or prosthetic demands of very active amputees.

## MISCELLANEOUS

Refer to the Supplier Manual for additional information on documentation requirements.

## APPENDICIES

PIM citations above denote references to CMS Program Integrity Manual, Internet Only Manual 100-08

## POLICY ARTICLE

**NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

- DME (Editor Note: Include specific name of DME item) covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

**Or**

- Prosthetic (Editor Note: Include specific name of prosthetic item) covered under the Prosthetic Devices benefit (Social Security Act §1861(s)(8)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

**WRITTEN ORDER PRIOR TO DELIVERY**

(Editor Note: Only when WOPD required)

- When the supplier is required to have a written order prior to delivery but bills an item without a detailed written order, the item will be denied as statutorily excluded.

**Or for Drugs**

- For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as non-covered.

**AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS**

ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the specified items are:

{Select codes from table below}

**Face-to-Face Visit Requirements:**

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the WOPD.
- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier

The first bullet, "For all claims for purchases or initial rentals", includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

**Prescription Requirements:**

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the DMEPOS supplier's possession BEFORE the item is delivered. The WOPD must include all of the items below:

- Beneficiary's name,
- Physician's name
- Date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:

- Verify that the in-person visit occurred within the six-months prior to the date of their prescription, and
- Have documentation of the face-to-face examination that was conducted, and
- Provide the DMEPOS supplier with copies of the in-person visit records.

**Date and Timing Requirements**

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than six months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

**Claim Denial**

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

## CODING GUIDELINES

(Editor Note: Only use first paragraph when items require PDAC review)

The only products which may be billed using codes XXX are those for which a written Coding Verification Review has been made by the Pricing, Data Analysis and Coding (PDAC) Contractor and subsequently published on the appropriate Product Classification List.

Suppliers should contact the PDAC Contractor for guidance on the correct coding of these items.

- Revised November 5, 2015
- Revised October 30, 2014
- Retracted October 02, 2014
- Revised September 25, 2014
- Posted March 02, 2012

## DME Documentation Checklist Updates for Therapeutic Shoes, PAP Devices, and Walkers

DME Provider Outreach and Education has updated the documentation checklist for Theraptuic Shoes for Persons with Diabetes, Positive Airway Pressure (PAP) Devices, and Walkers. For complete information, see the documentation checklist website.

## Face-to-Face Examination and Prescription Requirements Prior to Delivery of Certain DME Items Specified in the Affordable Care Act – Revised

**DME MAC Joint Publication**

- *Revised October 1, 2015*
- *Revised May 29, 2014*
- *Posted February 20, 2014*

This revision incorporates changes in the prescription requirements based upon the Medicare Access and SCHIP Reauthorization Act of 2015. The original provisions requiring that a physician co-sign a face-to-face examination that was performed by a PA, NP or CNS is removed.

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary within the six (6) months prior to the written order for certain items of DME (Refer to Table A for a list of items).

A face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier

The first bullet above, claims for purchases or initial rentals, includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g., from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes. This means that all Medicare payment requirements must be met, the same as any other item initially covered by Medicare.

These Affordable Care Act requirements are effective for claims for all of the specified items that require a new order (prescription) on or after July 1, 2013. Enforcement of these rules related to the face-to-face examination requirement and face-to-face documentation is delayed until further notice from CMS. This delay in enforcement does not apply to the prescription requirements for a Written Order Prior to Delivery or to the requirement to include the prescriber's NPI on the prescription.

ACA 6407 also contained a provision requiring that an MD or DO co-sign the face-to-face examination performed by a PA, NP or CNS. This requirement was eliminated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

## Face-To-Face Examination Requirements

The physician must have a face-to-face examination with the beneficiary in the six (6) months prior to the date of the written order for the specified items of DME.

This face-to-face requirement includes examinations conducted via the Centers for Medicare & Medicaid Services (CMS)-approved use of telehealth examinations (as described in Chapter 15 of the *Medicare Benefit Policy Manual* and Chapter 12 of the *Medicare Claims Processing Manual* – CMS Internet-Only Manuals, Publ. 100-02 and 100-04, respectively).

The DMEPOS supplier must have documentation of both the face-to-face visit and completed written order prior to delivery (WOPD) in their file prior to the delivery of these items.

For the physician prescribing a specified DME item:

- The face-to-face examination with the beneficiary must be conducted within the six (6) months prior to the date of the prescription.
- The face-to-face examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.
- Remember that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient medical information included in the medical record to demonstrate that the applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.
- The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:
  - Verify that the qualifying in-person visit occurred within the 6-months prior to the date of their prescription, and
  - Have documentation of the qualifying face-to-face examination that was conducted.
- The prescriber must provide a copy of the qualifying face-to-face examination and the prescription for the item(s) to the DMEPOS supplier before the item can be delivered.

## Prescription (order) Requirements

These specified items require a written order that must be obtained prior to delivery (WOPD). A WOPD is a standard Medicare detailed written order, which must be completed and in the DMEPOS supplier's possession BEFORE the item is delivered. The prescription (order) for the DME must include all of the items below:

- Beneficiary's name,
- Physician's Name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item
- The prescribing practitioner's National Provider Identifier (NPI),
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use

- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills, if applicable

For any of the specified items affected by this face-to-face requirement to be covered by Medicare, a written, signed and dated order must be received by the supplier prior to delivery of the item. If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DME items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, some of which are subject to these new order requirements. For example, oxygen concentrators (E1390) are often ordered in conjunction with portable oxygen (E0431). Orders for code E0431 require inclusion of the NPI while orders for E1390 do not.

## Date and Timing Requirements

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

## Claim Denial

Claims for the specified items subject to these face-to-face requirements and prescription requirements that do not meet the requirements specified above will be denied as statutorily noncovered - failed to meet statutory requirements.

## Local Coverage Determinations (LCD)

LCDs that contain items subject to these requirements are:

- Automatic External Defibrillators
- Cervical Traction Devices
- External Infusion Pumps
- High-frequency Chest Wall Oscillation Devices
- Home Glucose Monitors
- Hospital Beds
- Manual In-exsufflation Devices
- Manual Wheelchairs
- Nebulizers
- Osteogenesis Stimulators
- Oxygen
- Patient Lifts

- Pneumatic Compression Devices
- Positive Airway Pressure Devices
- Pressure Reducing Support Surfaces
- Respiratory Assist Devices
- Seat Lift Mechanisms
- Speech Generating Devices
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Wheelchair options and Accessories

These LCDs will be updated to include the requirements at a future date.

Numerous items are not included in a specific LCD. Some have coverage criteria described by National Coverage Determinations. Others have coverage determined on a case-by-case or individual-claim basis. This article and the associated CMS publications will constitute notice of these requirements for all of the applicable codes.

Refer to the applicable LCD, NCD and/or the Supplier Manual for additional information about WOPD requirements.

## TABLE A: DME List of Specified Covered Items

The DME list of Specified Covered Items is as follows. The original list was at 77 FR 44798. This original list contains some codes (codes marked with an "*") that have been deleted or that were made not valid for Medicare while other codes (codes marked with an "**") have had narrative changes. Updates to the list will be made as CMS releases revisions.

Refer to the Pricing, Data Analysis and Coding Contractor web site for information on coding at: http://www.dmepdac.com

| HCPCS Code | Description |
|---|---|
| **E0185** | Gel or gel-like pressure mattress pad |
| **E0188** | Synthetic sheepskin pad |
| **E0189** | Lamb's wool sheepskin pad |
| **E0194** | Air fluidized bed |
| **E0197** | Air pressure pad for mattress standard length and width |
| **E0198** | Water pressure pad for mattress standard length and width |
| **E0199** | Dry pressure pad for mattress standard length and width |
| **E0250** | Hospital bed fixed height with any type of side rails, mattress |
| **E0251** | Hospital bed fixed height with any type side rails without mattress |
| **E0255** | Hospital bed variable height with any type side rails with mattress |
| **E0256** | Hospital bed variable height with any type side rails without mattress |
| **E0260** | Hospital bed semi-electric (Head and foot adjustment) with any type side rails with mattress |
| **E0261** | Hospital bed semi-electric (head and foot adjustment) with any type side rails without mattress |
| **E0265** | Hospital bed total electric (head, foot and height adjustments) with any type side rails with mattress |
| **E0266** | Hospital bed total electric (head, foot and height adjustments) with any type side rails without mattress |
| **E0290** | Hospital bed fixed height without rails with mattress |

| HCPCS Code | Description |
|---|---|
| **E0291** | Hospital bed fixed height without rail without mattress |
| **E0292** | Hospital bed variable height without rail without mattress |
| **E0293** | Hospital bed variable height without rail with mattress |
| **E0294** | Hospital bed semi-electric (head and foot adjustment) without rail with mattress |
| **E0295** | Hospital bed semi-electric (head and foot adjustment) without rail without mattress |
| **E0296** | Hospital bed total electric (head, foot and height adjustments) without rail with mattress |
| **E0297** | Hospital bed total electric (head, foot and height adjustments) without rail without mattress |
| **E0300** | Pediatric crib, hospital grade, fully enclosed |
| **E0301** | Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, without mattress |
| **E0302** | Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, without mattress |
| **E0303** | Hospital bed Heavy Duty extra wide, with weight capacity 350-600 lbs with any type of rail, with mattress |
| **E0304** | Hospital bed Heavy Duty extra wide, with weight capacity greater than 600 lbs with any type of rail, with mattress |
| **E0424** | Stationary compressed gas Oxygen System rental; includes contents, regulator, nebulizer, cannula or mask and tubing |
| **E0431** | Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing |
| **E0433** | Portable liquid oxygen system |
| **E0434** | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask, and tubing |
| **E0439** | Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing |
| **E0441** | Oxygen contents, gaseous (1 months supply) |
| **E0442** | Oxygen contents, liquid (1 months supply) |
| **E0443** | Portable Oxygen contents, gas (1 months supply) |
| **E0444** | Portable oxygen contents, liquid (1 months supply) |
| **E0450** | Volume control ventilator without pressure support used with invasive interface |
| **E0457** | Chest shell |
| **E0459** | Chest wrap |
| **E0460** | Negative pressure ventilator portable or stationary |
| **E0461** | Volume control ventilator without pressure support node for a noninvasive interface |
| **E0462** | Rocking bed with or without side rail |
| **E0463** | Pressure support ventilator with volume control mode used for invasive surfaces |
| **E0464** | Pressure support vent with volume control mode used for noninvasive surfaces |
| **E0470** | Respiratory Assist Device, bi-level pressure capability, without backup rate used non-invasive interface |
| **E0471** | Respiratory Assist Device, bi-level pressure capability, with backup rate for a non-invasive interface |

| HCPCS Code | Description |
|---|---|
| **E0472** | Respiratory Assist Device, bi-level pressure capability, with backup rate for invasive interface |
| **E0480** | Percussor electric/pneumatic home model |
| **E0482** | Cough stimulating device, alternating positive and negative airway pressure |
| **E0483** | High Frequency chest wall oscillation air pulse generator system |
| **E0484** | Oscillatory positive expiratory device, non-electric |
| **E0570** | Nebulizer with compressor |
| **E0575** | Nebulizer, ultrasonic, large volume |
| **E0580** | Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter |
| **E0585** | Nebulizer with compressor & heater |
| **E0601** | Continuous airway pressure device |
| **E0607** | Home blood glucose monitor |
| **E0627** | Seat lift mechanism incorporated lift-chair |
| **E0628** | Separate Seat lift mechanism for patient owned furniture electric |
| **E0629** | Separate seat lift mechanism for patient owned furniture non-electric |
| **E0636** | Multi positional patient support system, with integrated lift, patient accessible controls |
| **E0650** | Pneumatic compressor non-segmental home model |
| **E0651** | Pneumatic compressor segmental home model without calibrated gradient pressure |
| **E0652** | Pneumatic compressor segmental home model with calibrated gradient pressure |
| **E0655** | Non-segmental pneumatic appliance for use with pneumatic compressor on half arm |
| **E0656** | Non-segmental pneumatic appliance for use with pneumatic compressor on trunk |
| **E0657** | Non-segmental pneumatic appliance for use with pneumatic compressor chest |
| **E0660** | Non-segmental pneumatic appliance for use with pneumatic compressor on full leg |
| **E0665** | Non-segmental pneumatic appliance for use with pneumatic compressor on full arm |
| **E0666** | Non-segmental pneumatic appliance for use with pneumatic compressor on half leg |
| **E0667** | Segmental pneumatic appliance for use with pneumatic compressor on full-leg |
| **E0668** | Segmental pneumatic appliance for use with pneumatic compressor on full arm |
| **E0669** | Segmental pneumatic appliance for use with pneumatic compressor on half leg |
| **E0671** | Segmental gradient pressure pneumatic appliance full leg |
| **E0672** | Segmental gradient pressure pneumatic appliance full arm |
| **E0673** | Segmental gradient pressure pneumatic appliance half leg |
| **E0675** | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency |
| **E0692** | Ultraviolet light therapy system panel treatment 4 foot panel |
| **E0693** | Ultraviolet light therapy system panel treatment 6 foot panel |
| **E0694** | Ultraviolet multidirectional light therapy system in 6 foot cabinet |
| **E0720** | Transcutaneous electrical nerve stimulation, two lead, local stimulation |
| **E0730** | Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation |

| HCPCS Code | Description |
|---|---|
| **E0731** | Form fitting conductive garment for delivery of TENS or NMES |
| **E0740** | Incontinence treatment system, Pelvic floor stimulator, monitor, sensor, and/or trainer |
| **E0744** | Neuromuscular stimulator for scoliosis |
| **E0745** | Neuromuscular stimulator electric shock unit |
| **E0747** | Osteogenesis stimulator, electrical, non-invasive, other than spine application. |
| **E0748** | Osteogenesis stimulator, electrical, non-invasive, spinal application |
| **E0749** | Osteogenesis stimulator, electrical, surgically implanted |
| **E0760** | Osteogenesis stimulator, low intensity ultrasound, non-invasive |
| **E0762** | Transcutaneous electrical joint stimulation system including all accessories |
| **E0764** | Functional neuromuscular stimulator, transcutaneous stimulations of muscles of ambulation with computer controls |
| **E0765** | FDA approved nerve stimulator for treatment of nausea & vomiting |
| **E0782** | Infusion pumps, implantable, Non-programmable |
| **E0783** | Infusion pump, implantable, Programmable |
| **E0784** | External ambulatory infusion pump |
| **E0786** | Implantable programmable infusion pump, replacement |
| **E0840** | Tract frame attach to headboard, cervical traction |
| **E0849** | Traction equipment cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible |
| **E0850** | Traction stand, free standing, cervical traction |
| **E0855** | Cervical traction equipment not requiring additional stand or frame |
| **E0856** | Cervical traction device, cervical collar with inflatable air bladder |
| **E0958**** | Manual wheelchair accessory, one-arm drive attachment |
| **E0959**** | Manual wheelchair accessory-adapter for Amputee |
| **E0960**** | Manual wheelchair accessory, shoulder harness/strap |
| **E0961**** | Manual wheelchair accessory wheel lock brake extension handle |
| **E0966**** | Manual wheelchair accessory, headrest extension |
| **E0967**** | Manual wheelchair accessory, hand rim with projections |
| **E0968*** | Commode seat, wheelchair |
| **E0969*** | Narrowing device wheelchair |
| **E0971**** | Manual wheelchair accessory anti-tipping device |
| **E0973**** | Manual wheelchair accessory, adjustable height, detachable armrest |
| **E0974**** | Manual wheelchair accessory anti-rollback device |
| **E0978*** | Manual wheelchair accessory positioning belt/safety belt/ pelvic strap |
| **E0980*** | Manual wheelchair accessory safety vest |
| **E0981**** | Manual wheelchair accessory Seat upholstery, replacement only |
| **E0982**** | Manual wheelchair accessory, back upholstery, replacement only |
| **E0983**** | Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick control |
| **E0984**** | Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control |

| HCPCS Code | Description |
|---|---|
| **E0985** | Wheelchair accessory, seat lift mechanism |
| **E0986**** | Manual wheelchair accessory, push activated power assist |
| **E0990**** | Manual wheelchair accessory, elevating leg rest |
| **E0992**** | Manual wheelchair accessory, elevating leg rest solid seat insert |
| **E0994*** | Arm rest |
| **E1014** | Reclining back, addition to pediatric size wheelchair |
| **E1015** | Shock absorber for manual wheelchair |
| **E1020** | Residual limb support system for wheelchair |
| **E1028**** | Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory |
| **E1029**** | Wheelchair accessory, ventilator tray |
| **E1030**** | Wheelchair accessory, ventilator tray, gimbaled |
| **E1031** | Rollabout chair, any and all types with castors 5" or greater |
| **E1035**** | Multi-positional patient transfer system with integrated seat operated by care giver |
| **E1036**** | Patient transfer system |
| **E1037** | Transport chair, pediatric size |
| **E1038**** | Transport chair, adult size up to 300lb |
| **E1039**** | Transport chair, adult size heavy duty >300lb |
| **E1161** | Manual Adult size wheelchair includes tilt in space |
| **E1227*** | Special height arm for wheelchair |
| **E1228*** | Special back height for wheelchair |
| **E1232** | Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system |
| **E1233**** | Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system |
| **E1234** | Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system |
| **E1235** | Wheelchair, pediatric size, rigid, adjustable, with seating system |
| **E1236** | Wheelchair, pediatric size, folding, adjustable, with seating system |
| **E1237** | Wheelchair, pediatric size, rigid, adjustable, without seating system |
| **E1238** | Wheelchair, pediatric size, folding, adjustable, without seating system |
| **E1296*** | Special sized wheelchair seat height |
| **E1297*** | Special sized wheelchair seat depth by upholstery |
| **E1298*** | Special sized wheelchair seat depth and/or width by construction |
| **E1310**** | Whirlpool non-portable |
| **E2502**** | Speech Generating Devices prerecord messages between 8 and 20 Minutes |
| **E2506**** | Speech Generating Devices prerecord messages over 40 minutes |
| **E2508**** | Speech Generating Devices message through spelling, manual type |
| **E2510**** | Speech Generating Devices synthesized with multiple message methods |
| **E2227**** | Rigid pediatric wheelchair adjustable |
| **K0001** | Standard wheelchair |
| **K0002** | Standard hemi (low seat) wheelchair |
| **K0003** | Lightweight wheelchair |
| **K0004** | High strength ltwt wheelchair |

# DOCUMENTATION

| HCPCS Code | Description |
|---|---|
| **K0005** | Ultra Lightweight wheelchair |
| **K0006** | Heavy duty wheelchair |
| **K0007** | Extra heavy duty wheelchair |
| **K0009** | Other manual wheelchair/base |
| **K0606**** | AED garment with electronic analysis |
| **K0730** | Controlled dose inhalation drug delivery system |

## Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

**Source:** Internet Only Manual, Publication 100-8, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

## Physician Letter – Face-to-Face and Written Order Requirements for High Cost DME

This letter to physicians provides additional guidance for the Affordable Care Act requirements.

# DRUGS AND BIOLOGICALS

## Authoritative Sources Used in Determination of "Medically-Accepted Indication" of Drugs and Biologicals Used Off-label in Anti-Cancer Chemotherapeutic Regimen

MLN Matters® Number: MM9386
Related Change Request (CR) #: CR 9386
Related CR Release Date: November 6, 2015
Effective Date: August 12, 2015
Related CR Transmittal #: R212BP
Implementation Date: February 10, 2016

### Provider Types Affected

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

### What You Need to Know

This article is based on Change Request (CR) 9386 which announces that effective for services on or after August 12, 2015, the Centers for Medicare & Medicaid Services (CMS) is adding Wolters Kluwer Lexi-Drugs® to the list of authoritative compendia for use in the determination of a medically-accepted indication of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.

## Background

The Social Security Act (Section 1861(t)(2)(B)(ii)(I); as amended by the Deficit Reduction Act of 2005 Pub. Law 109-171; Section 6001(f)(1)), recognized the following three compendia as authoritative sources for use in the determination of a "medically accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

1. American Medical Association Drug Evaluations (AMA-DE);
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication; and
3. American Hospital Formulary Service-Drug Information (AHFS-DI).

These authoritative sources could be used in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen, unless:

- The Secretary of Health and Human Services (HHS) determined that the use is not medically appropriate; or
- The use is identified as not indicated in one or more such compendia.

This provision was implemented through instructions to the MACs in the "Medicare Benefit Policy Manual" (Chapter 15, Section 50.4.5).

**Due to changes in the pharmaceutical reference industry:**

- The AHFS-DI was the only remaining statutorily-named compendia available for CMS reference;
- The AMA-DE and USP-DI are no longer published;
- Thomson Micromedex designated Drug Points was the successor to USP-DI; but
- Drug Points has since been deleted from the list of recognized compendia.

In January 2008, CMS established, via the Physician Fee Schedule Final Rule for calendar year 2008:

- A process for revising the list of compendia, as authorized under the Social Security Act (Section 1861(t)(2)), and
- A definition for "compendium."

This sub-regulatory process for revising the list of compendia is described in the "Medicare Benefit Policy Manual" (Chapter 15, Section 50.4.5.1).

**Based on this process, CMS updated the list in 2008 to include the following four compendia:**

1. Existin – American Hospital Formulary Service-Drug Information (AHFS-DI),
2. Effective June 5, 2008 – National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
3. Effective June 10, 2008 – Truven Health Analytics Micromedex DrugDex, and
4. Effective July 2, 2008 – Elsevier/Gold Standard Clinical Pharmacology.

On August 12, 2015, CMS announced the addition of Wolters Kluwer Lexi-Drugs® to the above list of four compendia used by the Medicare program in the determination of a "medically-accepted indication" for off-label drugs and biologics used in an anticancer chemotherapeutic treatment regimen. This is effective for services on or after August 12, 2015.

Further details on this issue are in the revised Chapter 15, Section 50.4.5.1 of the "Medicare Benefit Policy Manual," which is an attachment to CR9386.

## Additional Information

The official instruction, CR 9386, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Down loads/R212BP.pdf on the CMS website.

# Coverage and Coding – New Oral Antiemetic Drug Varubi

## Joint DME MAC Publication

The U.S. Food and Drug Administration approved Varubi™ (rolapitant) on September 2, 2015. Rolapitant is a substance P/neurokinin1 (NK-1) receptor antagonist medication used to treat nausea and vomiting in patients undergoing emetogenic cancer chemotherapy.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated rolapitant and determined that it is eligible for inclusion in the DME MAC Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) Local Coverage Determination (LCD), effective for claims with dates of service on or after September 02, 2015.

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

For dates of service on or after September 2, 2015, claims for rolapitant must be billed using HCPCS code:

> **Q0181** – UNSPECIFIED ORAL DOSAGE FORM, FDA APPROVED PRESCRIPTION ANTI-EMETIC, FOR USE AS A COMPLETE THERAPEUTIC SUBSTITUTE FOR A IV ANTI-EMETIC AT THE TIME OF CHEMOTHERAPY TREATMENT, NOT TO EXCEED A 48 HOUR DOSAGE REGIMEN.
>
> Q0181 must be billed on the same claim with dexamethasone (J8540) and an oral 5HT3 antagonist to qualify for consideration of coverage.

If the three drug combination of an oral 5HT3 antagonist, rolapitant (Q0181) and dexamethasone (J8540) are used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of the LCD regarding oral antiemetics, a KX modifier must be added to each code. In addition to the diagnosis code corresponding to the beneficiary's cancer diagnosis, claims for these drugs must also be accompanied with a diagnosis code of an encounter for antineoplastic chemotherapy (Z51.11).

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

If the three drug combination of rolapitant (Q0181), an oral 5HT3 antagonist and dexamethasone (J8540) are not used in conjunction with one of the anticancer chemotherapeutic agents listed in the Coverage Indications, Limitations and/or Medical Necessity section of this policy, the GA or GZ modifier must be added to the claim lines for Q0181 and J8540 and the 5HT3 antagonist. When there is an expectation of a denial as not reasonable and necessary, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

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

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

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

## 2015 Ask the Contractor Teleconferences

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

**Upcoming 2015 ACTs: 3 p.m. CT**

- March 12
- June 11
- September 10
- December 10

**Toll Free number: (800) 230-1074**

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

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

## DME on Demand – Cervical Traction: Coding and Billing

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

**This session will include:**

- Coding
- Billing Reminders
- Advanced Beneficiary Notice of Noncoverage
- Traction Equipment
- Modifiers
- Resources

### Viewing Presentation

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

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

## DME on Demand – Cervical Traction Devices: Coverage Criteria

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

**This session will include:**

- Coverage
- Detailed Written Order (DWO) or Written Order Prior to Delivery (WOPD)
- Cervical Traction Devices
- Traction Frame and Stand
- Cervical Collar

- Cervical Orthosis
- Resources

### Viewing Presentation

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

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

## DME on Demand – Pneumatic Compression Devices – Coding

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

**This session will include:**

- Coding
- Pneumatic Compression Devices
- Non-segmented Compressor
- Segmented Compressor
- Appliances/Sleeves
- Pricing, Data Analysis and Coding (PDAC)

### Viewing Presentation

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

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

## DME on Demand – Pneumatic Compression Devices – Coverage Criteria

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

**This session will include:**

- Coverage Criteria
- Pneumatic Compression Devices
- Lymphedema
- Conservative Therapy
- Chronic Venous Insufficiency
- General Coverage
- Medical Necessity
- Not Reasonable and Necessary

### Viewing Presentation

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

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

## DME on Demand – Pneumatic Compression Devices – Documentation

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

**This session will include:**

- Certificates of Medical Necessity (CMNs)
- Making Changes to a CMN
- CMS Form 846
- Written Order Prior to Delivery (WOPD)
- Additional Documentation

### Viewing Presentation

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

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

## DME on Demand – RAD – Continued Use Beyond Three Months

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

**This session will include:**

- Respiratory Assist Device (RAD) Coverage Criteria
- RAD Without Backup
- Billing Fourth Month
- Re-evaluation and Adherence
- Failure of RAD Trial
- Discontinuation of Usage
- Resources

### Viewing Presentation

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

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

## DME on Demand – RAD – Entering Medicare and RUL Requirements

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

**This session will include:**

- Respiratory Assist Device (RAD) Coverage Criteria
- RAD Without Backup
- RAD With Backup
- Beneficiaries Entering Medicare
- Beneficiaries Entering Medicare Claims
- Replacement
- Reasonable Useful Lifetime (RUL) Beneficiary Claims Less Than Five Years

- Replacement Inside Five Years
- RUL Beneficiary Claims Greater Than Five Years
- RUL
- Resources

### Viewing Presentation

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

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

## DME on Demand – RAD – Initial 12 Week Coverage

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

**This session will include:**

- Respiratory Assist Device (RAD) Coverage Criteria
- RAD Coverage Groups
- Restrictive Thoracic Disorders
- Severe COPD E0470
- Severe COPD E0471
- CSA or CompSA
- Central Sleep Apnea
- Complex Sleep Apnea
- Hypoventilation Syndrome
- Resources

### Viewing Presentation

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

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

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

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from May 2015 through August 2015 are as follows:

The E0181 review currently has an overall potential improper payment rate of 54% and the E0185 review currently has overall claim potential improper payment rate of 57%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Documentation submitted does not meet coverage criteria.
- Documentation does not contain a valid date stamp or similar.
- The order is incomplete or missing elements.
- No office notes or medical records were provided.

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

# EDUCATIONAL

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

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

The E2402 review currently has an overall potential improper payment rate of 74%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No office notes or medical records were received.
- The signature requirements were not met.
- The documentation submitted does not include a statement from the treating physician describing the initial condition of the wound and efforts to address all aspects of wound care.

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

# ENROLLMENT

## 2016 Open Enrollment Period

The 2016 Annual Participation Open Enrollment Period runs mid-November through December 31, 2015. The open enrollment period allows Medicare suppliers to revisit their choice to accept Medicare assignment for claims payment. The participation status only affects how you are reimbursed from Medicare. Changing your status to non-participating does not terminate your Medicare billing privileges. If you do not wish to make any changes to your participation status, it is not necessary to respond during this period.

- To change your status to participating, submit a request on the CMS-460 form signed by the authorized or delegated official as previously reported to the NSC.
- To change your status to non-participating, submit a request on your company's letterhead signed by the company's authorized or delegated official as previously reported to the NSC.

The CMS-460 participation agreement can be downloaded from the CMS website as a PDF.

**Note:** If you are currently enrolled in the Medicare program other than as a DMEPOS supplier, you may only change your participation status with one carrier as the status will be the same with all Medicare contractors.

For more information, contact NSC Customer Service at 866-238-9652, M-F, 9 am - 5 pm, ET.

## Ordering-Referring Providers in Medicare Part B – DME – Part A Home Health Agency Claims – Full Implementation of Edits – Seventh Revision

### MLN Matters® Number: SE1305 Revised
### Related Change Request (CR) #: 6421, 6417, 6696, 6856
### Related CR Transmittal #: R642OTN, R643OTN, R328PI, and R781OTN

This article was revised on October 21, 2015, to add a statement on page 8, item c. regarding a legislative change impacting the two year opt-out period. All other information remains the same.

### Provider Types Affected

This MLN Matters® Special Edition Article is intended for:

- Physicians and non-physician practitioners (including interns, residents, fellows, and those who are employed by the Department of Veterans Affairs (DVA), the Department of Defense (DoD), or the Public Health Service (PHS)) who order or refer items or services for Medicare beneficiaries,

- Part B providers and suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who submit claims to carriers, Part A/B Medicare Administrative Contractors (MACs), and DME MACs for items or services that they furnished as the result of an order or a referral, and
- Part A Home Health Agency (HHA) services who submit claims to Regional Home Health Intermediaries (RHHIs), Fiscal Intermediaries (FIs, who still maintain an HHA workload), and Part A/B MACs.
- Optometrists may only order and refer DMEPOS products/services and laboratory and X-Ray services payable under Medicare Part B.

## Provider Action Needed

If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or by completing the paper enrollment application (CMS-855O). Review the background and additional information below and make sure that your billing staff is aware of these updates.

- What Providers Need to Know

  **Phase 1:** Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication.

  **Phase 2:** Effective January 6, 2014, CMS will turn on the edits to deny Part B clinical laboratory and imaging, DME, and Part A HHA claims that fail the ordering/referring provider edits.

  Claims submitted identifying an ordering/referring provider and the required matching NPI is missing will continue to be rejected. Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit will not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services, including home health, DMEPOS, imaging and clinical laboratory.

Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record and must be of a specialty that is eligible to order and refer. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first four letters of the last name. **When submitting the CMS-1500 or the CMS-1450, please only include the first and last name as it appears on the ordering and referring file found on** https://data.cms.gov **on the CMS website.** Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields.

All enrollment applications, including those submitted over the Internet, require verification of the information reported. Sometimes, Medicare enrollment contractors may request additional information in order to process the enrollment application. Waiting too long to begin this process could mean that your enrollment application may not be processed prior to the implementation date of the ordering/referring Phase 2 provider edits.

## Background

The Affordable Care Act, Section 6405, "Physicians Who Order Items or Services are required to be Medicare Enrolled Physicians or Eligible Professionals," requires physicians or other eligible professionals to be enrolled in the Medicare Program to order or refer items or services for Medicare beneficiaries. Some physicians or other eligible professionals do not and will not send claims to a Medicare contractor for the services they furnish and therefore may not be enrolled in the Medicare program. Also, effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending physician on the claim if that service or item was the result of an order or referral. Effective May 23, 2008, the unique identifier was determined to be the NPI. The Centers for Medicare & Medicaid Services (CMS) has implemented edits on ordering and referring providers when they are required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims from Medicare providers or suppliers who furnished items or services as a result of orders or referrals.

**Below are examples of some of these types of claims:**

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A Home Health Agencies (HHA).

**Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Medicare beneficiaries. They are as follows:**

- Physicians (doctor of medicine or osteopathy, doctor of dental medicine, doctor of dental surgery, doctor of podiatric medicine, doctor of optometry, optometrists may only order and refer DMEPOS products/ services and laboratory and X-Ray services payable under Medicare Part B.)
- Physician Assistants,
- Clinical Nurse Specialists,
- Nurse Practitioners,
- Clinical Psychologists,
- Interns, Residents, and Fellows,
- Certified Nurse Midwives, and
- Clinical Social Workers.

CMS emphasizes that generally Medicare will only reimburse for specific items or services when those items or services are ordered or referred by providers or suppliers authorized by Medicare statute and regulation to do so. Claims that a billing provider or supplier submits in which the ordering/referring provider or supplier is not authorized by statute and regulation will be denied as a non-covered service. The denial will be based on the fact that neither statute nor regulation allows coverage of certain services when ordered or referred by the identified supplier or provider specialty.

**CMS would like to highlight the following limitations:**

- Chiropractors are not eligible to order or refer supplies or services for Medicare beneficiaries. All services ordered or referred by a chiropractor will be denied.
- Home Health Agency (HHA) services may only be ordered or referred by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM). Claims for HHA services ordered by any other practitioner specialty will be denied.
- Optometrists may only order and refer DMEPOS products/services, and laboratory and X-Ray services payable under Medicare Part B.

## Questions and Answers Relating to the Edits

1. **What are the ordering and referring edits?**

   The edits will determine if the Ordering/Referring Provider (when required to be identified in Part B clinical laboratory and imaging, DME, and Part A HHA claims) (1) has a current Medicare enrollment record and contains a valid NPI (the name and NPI must match), and (2) is of a provider type that is eligible to order or refer for Medicare beneficiaries (see list above).

2. **Why did Medicare implement these edits?**

   These edits help protect Medicare beneficiaries and the integrity of the Medicare program.

3. **How and when will these edits be implemented?**

   These edits were implemented in two phases:

   **Phase 1** – Informational messaging: Began October 5, 2009, to alert the billing provider that the identification of the ordering/referring provider is missing, incomplete, or invalid, or that the ordering/referring provider is not eligible to order or refer. The informational message on an adjustment claim that did not pass the edits indicated the claim/service lacked information that was needed for adjudication. The informational messages used are identified below:

   - For Part B providers and suppliers who submit claims to carriers:
     - **N264** – Missing/incomplete/invalid ordering provider name
     - **N265** – Missing/incomplete/invalid ordering provider primary identifier
   - For adjusted claims, the Claims Adjustment Reason Code (CARC) code 16 (Claim/service lacks information which is needed for adjudication.) is used. DME suppliers who submit claims to carriers (applicable to 5010 edits):
     - **N544** – Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future
   - For Part A HHA providers who order and refer, the claims system initially processed the claim and added the following remark message:
     - **N272** – Missing/incomplete/invalid other payer attending provider identifier
   - For adjusted claims the CARC code 16 and/or the RARC code N272 was used.

**CMS has taken actions to reduce the number of informational messages.** In December 2009, CMS added the NPIs to more than 200,000 PECOS enrollment records of physicians and non-physician practitioners who are eligible to order and refer but who had not updated their PECOS enrollment records with their NPIs.1 On January 28, 2010, CMS made available to the public, via the Downloads section of the "Ordering Referring Report" page on the Medicare provider/supplier enrollment website, a file containing the NPIs and the names of physicians and non-physician practitioners who have current enrollment records in PECOS and are of a type/specialty that is eligible to order and refer. The file, called the Ordering Referring Report, lists, in alphabetical order based on last name, the NPI and the name (last name, first name) of the physician or non-physician practitioner. To keep the available information up to date, CMS will replace the Report twice a week. At any given time, only one Report (the most current) will be available for downloading. To learn more about the Report and to download it, go to https://data.cms.gov on the CMS website.

(1 NPIs were added only when the matching criteria verified the NPI.)

**Phase 2:** Effective January 6, 2014, CMS will turn on the Phase 2 edits. In Phase 2, if the ordering/referring provider does not pass the edits, the claim will be denied. This means that the billing provider will not be paid for the items or services that were furnished based on the order or referral.

- Below are the denial edits for Part B providers and suppliers who submit claims to Part A/B MACs, including DME MACs:
  - **254D or 001L** – Referring/Ordering Provider Not Allowed To Refer/Order
  - **255D or 002L** – Referring/Ordering Provider Mismatch

- CARC code 16 or 183 and/or the RARC code N264, N574, N575 and MA13 shall be used for denied or adjusted claims.

  Claims submitted identifying an ordering/referring provider and the required matching NPI is missing (edit 289D) will continue to be rejected. CARC code 16 and/or the RARC code N265, N276 and MA13 shall be used for rejected claims due to the missing required matching NPI.

- Below are the denial edits for Part A HHA providers who submit claims:
  - **37236: This reason code will assign when:**
    - The statement "From" date on the claim is on or after the date the phase 2 edits are turned on
    - The type of bill is '32' or '33'
    - Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claim is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code.
  - **37237: This reason code will assign when:**
    - The statement "From" date on the claim is on or after the date the phase 2 edits are turned on
    - The type of bill is '32' or '33'
    - The type of bill frequency code is '7' or 'F-P'
    - Covered charges or provider reimbursement is greater than zero but the attending physician NPI on the claim is not present in the eligible attending physician file from PECOS or the attending physician NPI on the claims is present in the eligible attending physician files from PECOS but the name does not match the NPI record in the eligible attending physician files from PECOS or the specialty code is not a valid eligible code.

## Effect of Edits on Providers

**I order and refer. How will I know if I need to take any sort of action with respect to these two edits?**

In order for the claim from the billing provider (the provider who furnished the item or service) to be paid by Medicare for furnishing the item or service that you ordered or referred, you, the ordering/referring provider, need to ensure that:

**A. You have a current Medicare enrollment record.**

- If you are not sure you are enrolled in Medicare, you may:
  - Check the Ordering Referring Report and if you are on that report, you have a current enrollment record in Medicare and it contains your NPI;
  - Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in Medicare and it contains the NPI; or
  - Use Internet-based PECOS to look for your Medicare enrollment record (if no record is displayed, you do not have an enrollment record in Medicare).
  - If you choose iii, please read the information on the Medicare provider/supplier enrollment web page about Internet-based PECOS before you begin.

**B. If you do not have an enrollment record in Medicare.**

- You need to submit either an electronic application through the use of internet-based PECOS or a paper enrollment application to Medicare.
  - **For paper applications** – fill it out, sign and date it, and mail it, along with any required supporting paper documentation, to your designated Medicare enrollment contractor.
  - **For electronic applications** – complete the online submittal process and either e-sign or mail a printed, signed, and dated Certification Statement and digitally submit any required supporting paper documentation to your designated Medicare enrollment contractor.

- In either case, the designated enrollment contractor cannot begin working on your application until it has received the signed and dated Certification Statement.
- If you will be using Internet-based PECOS, please visit the Medicare provider/supplier nrollment web page to learn more about the web-based system before you attempt to use it. Go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html, click on "Internet-based PECOS" on the left-hand side, and read the information that has been posted there. Download and read the documents in the Downloads Section on that page that relate to physicians and non-physician practitioners. A link to Internet-based PECOS is included on that web page.
- If you order or refer items or services for Medicare beneficiaries and you do not have a Medicare enrollment record, you need to submit an enrollment application to Medicare. You can do this using Internet-based PECOS or by completing the paper enrollment application (CMS-855O). Enrollment applications are available via internet-based PECOS or .pdf for downloading from the CMS forms page (http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html).

**C. You are an opt-out physician and would like to order and refer services. What should you do?**

If you are a physician who has opted out of Medicare, you may order items or services for Medicare beneficiaries by submitting an opt-out affidavit to a Medicare contractor within your specific jurisdiction. Your opt-out information must be current (an affidavit must be completed every 2 years, and the NPI is required on the affidavit). Note, however, that prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for 2 years. As a result of changes made by MACRA, valid opt-out affidavits signed on or after June 16, 2015, will automatically renew every 2 years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare Administrative Contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

**D. You are of a type/specialty that can order or refer items or services for Medicare beneficiaries.**

When you enrolled in Medicare, you indicated your Medicare specialty. Any physician specialty (Chiropractors are excluded) and only the non-physician practitioner specialties listed above in this article are eligible to order or refer in the Medicare program.

**E. I bill Medicare for items and services that were ordered or referred. How can I be sure that my claims for these items and services will pass the Ordering/Referring Provider edits?**

- You need to ensure that the physicians and non-physician practitioners from whom you accept orders and referrals have current Medicare enrollment records and are of a type/specialty that is eligible to order or refer in the Medicare program. If you are not sure that the physician or non-physician practitioner who is ordering or referring items or services meets those criteria, it is recommended that you check the Ordering Referring Report described earlier in this article.
- Ensure you are correctly spelling the Ordering/Referring Provider's name.
- If you furnished items or services from an order or referral from someone on the Ordering Referring Report, your claim should pass the Ordering/Referring Provider edits.
- The Ordering Referring Report will be replaced twice a week to ensure it is current. It is possible that you may receive an order or a referral from a physician or non-physician practitioner who is not listed in the Ordering Referring Report but who may be listed on the next Report.

**F. Make sure your claims are properly completed.**

- On paper claims (CMS-1500), in item 17, only include the first and last name as it appears on the Ordering and Referring file found on CMS.gov.
- On paper claims (CMS-1450), you would capture the attending physician's last name, first name and NPI on that form in the applicable sections. On the most recent form it would be fields in FL 76.
- On paper claims (CMS-1500 and CMS-1450), do not enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the Ordering/Referring name field, as their use could cause the claim to fail the edits.

- Ensure that the name and the NPI you enter for the Ordering/Referring Provider belong to a physician or non-physician practitioner and not to an organization, such as a group practice that employs the physician or non-physician practitioner who generated the order or referral.
- Make sure that the qualifier in the electronic claim (X12N 837P 4010A1) 2310A NM102 loop is a 1 (person). Organizations (qualifier 2) cannot order and refer.

If there are additional questions about the informational messages, Billing Providers should contact their local A/B MAC, or DME MAC.

Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability. Therefore, an Advance Beneficiary Notice is not appropriate in this situation. This is consistent with the preamble to the final rule which implements the Affordable Care Act requirement that physicians and eligible professionals enroll in Medicare to order and certify certain Medicare covered items and services including home health, DMEPOS, imaging and clinical laboratory.

**G. What if my claim is denied inappropriately?**

If your claim did not initially pass the Ordering/Referring provider edits, you may file an appeal through the standard claims appeals process or work through your A/B MAC or DME MAC.

**H. How will the technical vs. professional components of imaging services be affected by the edits?**

Consistent with the Affordable Care Act and 42 CFR 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: IDTFs, mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

**I. Are the Phase 2 edits based on date of service or date of claim receipt?**

The Phase 2 edits are effective for claims with dates of service on or after January 6, 2014.

**J. A Medicare beneficiary was ordered a 13-month DME capped rental item.**

Medicare has paid claims for rental months 1 and 2. The equipment is in the 3rd rental month at the time the Phase 2 denial edits are implemented. The provider who ordered the item has been deactivated. How will the remaining claims be handled? **Claims for capped rental items will continue to be paid for up to 13 months from the physician's date of deactivation to allow coverage for the duration of the capped rental period.**

## Additional Guidance

**1. Terminology:**

Part B claims use the term "ordering/referring provider" to denote the person who ordered, referred, or certified an item or service reported in that claim. The final rule uses technically correct terms: 1) a provider "orders" non-physician items or services for the beneficiary, such as DMEPOS, clinical laboratory services, or imaging services and 2) a provider "certifies" home health services to a beneficiary. The terms "ordered" "referred" and "certified" are often used interchangeably within the health care industry. Since it would be cumbersome to be technically correct, CMS will continue to use the term "ordered/referred" in materials directed to a broad provider audience.

**2. Orders or referrals by interns or residents:**

The IFC mandated that all interns and residents who order and refer specify the name and NPI of a teaching physician (i.e., the name and NPI of the teaching physician would have been required on the claim for service(s)). The final rule states that State-licensed residents may enroll to order and/or refer and may be listed on claims. Claims for covered items and services from un-licensed interns and residents must still specify the name and NPI of the teaching physician. However, if States provide provisional licenses or otherwise permit residents to order and refer services, CMS will allow interns and residents to enroll to order and refer, consistent with State law.

3. **Orders or referrals by physicians and non-physician practitioners who are of a type/specialty that is eligible to order and refer who work for the Department of Veterans Affairs (DVA), the Public Health Service (PHS), or the Department of Defense (DoD)/Tricare:**

   These physicians and non-physician practitioners will need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries. They may do so by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

4. **Orders or referrals by dentists:**

   Most dental services are not covered by Medicare; therefore, most dentists do not enroll in Medicare. Dentists are a specialty that is eligible to order and refer items or services for Medicare beneficiaries (e.g., to send specimens to a laboratory for testing). To do so, they must be enrolled in Medicare. They may enroll by filling out the paper CMS-855O or they may use Internet-based PECOS. They will not be submitting claims to Medicare for services they furnish to Medicare beneficiaries.

## Additional Information

For more information about the Medicare enrollment process, visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html or contact the designated Medicare contractor for your State. Medicare provider enrollment contact information for each State can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Contact_list.pdf on the CMS website.

The Medicare Learning Network® (MLN) fact sheet titled, "Medicare Enrollment Guidelines for Ordering/Referring Provider," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_OrderReferProv_factSheet_ICN906223.pdf on the CMS website.

You must obtain a National Provider Identifier (NPI) prior to enrolling in Medicare. Your NPI is a required field on your enrollment application. Applying for the NPI is a separate process from Medicare enrollment. To obtain an NPI, you may apply online at https://nppes.cms.hhs.gov/NPPES/Welcome.do on the CMS website. For more information about NPI enumeration, visit http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html on the CMS website.

## Additional Article Updates

MLN Matters® Article MM7097, "Eligible Physicians and Non-Physician Practitioners Who Need to Enroll in the Medicare Program for the Sole Purpose of Ordering and Referring Items and Services for Medicare Beneficiaries," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7097.pdf on the CMS website.

MLN Matters® Article MM6417, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Claims Processed by Medicare Carriers and Part B Medicare Administrative Contractors (MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6417.pdf on the CMS website.

MLN Matters® Article MM6421, "Expansion of the Current Scope of Editing for Ordering/Referring Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers' Claims Processed by Durable Medical Equipment Medicare Administrative Contractors (DME MACs)," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6421.pdf on the CMS website;

MLN Matters® Article MM6129, "New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services," is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6129.pdf on the CMS website.

MLN Matters Article MM6856, "Expansion of the Current Scope for Attending Physician Providers for free-standing and provider-based Home Health Agency (HHA) Claims processed by Medicare Regional Home Health Intermediaries (RHHIs), is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6856.pdf on the CMS website.

## ENROLLMENT

MLN Matters Article SE1311, " Opting out of Medicare and/or Electing to Order and Refer Services" is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf informs ordering and referring providers about the information they must provide in a written affidavit to their Medicare contractor when they opt-out of Medicare.

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

Important information for physicians and non-physician practitioners who opt out of Medicare and/or elect to order and certify services to Medicare beneficiaries is available in MLN Matters® Article SE1311at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1311.pdf on the CMS website.

## EXTERNAL INFUSION PUMPS

### Billing Instructions – Completing External Infusion Pump LCD DIF for Levodopa – Carbidopa Enteral Suspension

#### DME MAC Joint Publication

A DME Information Form (DIF) which has been completed, signed, and dated by the supplier, must be kept on file by the supplier and made available upon request. Recently, the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have received questions regarding the completion of the External Infusion Pump DIF (DME 09.03) for Levodopa-Carbidopa enteral suspension (Duopa).

For claims with an initial date of service on or after November 15, 2015, suppliers must submit an INITIAL DIF in accordance with the instructions below. For beneficiaries who are currently receiving Duopa, the first claim submitted on or after November 15, 2015, must include a REVISED DIF submitted in accordance with the instructions below.

#### DIF Questions #1 and #4

These questions require no special instructions, and should be completed as required.

#### DIF Question #2

Levodopa-Carbidopa enteral suspension is currently billed using HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). When a NOC drug code is billed for use with an external infusion pump, the name of the drug must be printed in response to question #2 on the DIF, and the claim must be accompanied by:

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

#### DIF Question #3

For the route of administration, the supplier must check option #4 – "Other" – as the answer to this question.

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

## External Infusion Pump – Response to Comment Summary

The public comment period for the draft local coverage determination for External Infusion Pump (EIP) closed on August 31, 2015. A public meeting was held on August 26, 2015.

1. Five commenters suggested a liberalization of the prescribing provider (APP/NP/PA or MD).

   **Response:** The medical directors agree, and language in the final policy is reflective of that suggestion. However, since coverage encompasses "Bridge" therapy for patients eligible for and awaiting mechanical circulatory support (MCS)/cardiac transplantation, it is the judgment of the medical directors that a cardiologist with training in the management of advanced heart failure must perform the initial evaluation.

2. Two commenters inquired about a diagnosis code (ICD-10) cross-walk.

   **Response:** The parenteral inotropic therapy section of the draft policy does not contain any ICD-9 diagnoses codes which require a cross-walk to ICD-10 codes. Moreover, the draft policy defines coverage based on the severity of heart failure (Class IV or Stage D) and not on the diagnosis code(s).

3. Two commenters inquired as to what specific documentation will be required to document "improvement in beneficiary symptoms of heart failure while on the selected inotropic drug at the time of discharge from an inpatient or skilled nursing care facility."

   **Response:** This is not a new requirement. Under the existing policy, it must be clear from the documentation in the beneficiary's medical record that their symptoms of heart failure improved while on the selected drug at the time of discharge from the inpatient or skilled nursing facility. As a reminder, the Centers for Medicare & Medicaid Services (CMS) provides guidance to contractors and providers in the Program Integrity Manual (Internet-only Manual 100-08, Chapter 5, §5.7) with respect to documentation in medical records. The PIM §5.7 states (in pertinent part):

   *For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.*

   *The patient's medical record is not limited to the physician's office records. It may include hospital, nursing home, or HHA records and records from other health care professionals.*

4. Four commenters suggested coverage expansion to include patients with New York Heart Association (NYHA) Class IIIb/ACC Stage C heart failure.

   **Response:** Current ACCF/AHA heart failure guidelines are not supportive[1], and the final policy will not expand coverage. One commenter submitted one reference to support their contention that inotropes do not increase mortality in this sub-group of patients. The citation was a review article, which did not specifically address patients with NYHA Class IIIb/ACC Stage C heart failure.[2] Three commenters did not submit any literature in support of their recommendation.

5. One commenter requested clarification on the credentials of the "prescribing practitioner".

   **Response:** The policy requires that the initial evaluation be performed by a cardiologist with training in the management of advanced heart failure.

6. One commenter suggested modifying the draft language regarding "continued need", in order to accommodate beneficiaries in rural areas.

   **Response:** The medical directors agree that some health care facilities in rural areas may not have structured heart failure teams, and language in the final policy is reflective of that suggestion.

[1] 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Clyde W. Yancy, MD, MSc, FACC, FAHA; Mariell Jessup, MD, FACC, FAHA; Biykem Bozkurt, MD, PhD, FACC, FAHA; et al. J Am Coll Cardiol. 2013;62(16):e147-e239.

[2] Guglin M, Kaufman M. International Journal of General Medicine 2014:7 237–251

7. One commenter suggested clarifying the language regarding Guideline Directed Medical Therapy (GMDT).

   **Response:** The draft policy GDMT language requires documentation of the use of appropriate, primarily Class I ACCF/AHA guideline recommended therapies for this group of patients; prior to a trial of parenteral inotropic therapy.

## Updated External Infusion Pump Policy – Parenteral Inotropic Therapy FAQs

**Question 1:** Guideline-directed medical therapy (GDMT) is compliance with optimal medical therapy as defined by ACCF/AHA guidelines recommended therapies (primarily Class I recommendations). These include the use of diuretics, ACE inhibitors or ARB antagonists, beta-blockers, aldosterone antagonists, hydralazine & isosorbide dinitrate, and statins, as appropriate. How are we supposed to support the word as appropriate? What if the patient could not take a statin due to allergy/intolerance? Does the record have to indicate as appropriate and why a patient did not take one of these drugs?

**Answer:** "As appropriate" simply means that the course of action is proper, given the set of circumstances. In the specific example cited above, it is obviously inappropriate to give a statin when the patient is allergic or intolerant. Similarly, if the patient has had a cough associated with ACE inhibitors, the policy's use of "as appropriate" would not require the patient to use that class of drugs. However, in such instances, the contemporaneous patient's medical record should clearly note the reasons for deviating from GDMT.

**Question 2:** The parenteral inotropic drug can be prescribed by someone other than the evaluating cardiologist. How is a prescriber supposed to evaluate that the initial evaluation was performed by a cardiologist with training in the management of advanced heart failure?

**Answer:** The prescriber should be familiar with the expertise and training of the consultants utilized for the treatment of their advanced heart failure patients.

**Question 3:** Are there professional certification letters after an MD name that indicate a cardiologist has training in advanced HF?

**Answer:** Professional certification letters after the name of the evaluating cardiologist are not a requirement. However, the evaluating cardiologist may indicate "FACC", "Board-Certified in Cardiology" or "Board Certified in Advanced Heart Failure and Transplant Cardiology" on their letterheads, progress notes or other documentation.

**Question 4:** How can the prescriber obtain proof of the cardiologist's credentials?

**Answer:** Proof of the evaluating cardiologist's credentials is not required prior to claim submission. Upon an audit, evidence of board certification and or an attestation from the evaluating cardiologist may be requested.

**Question 5:** What type of records would be used to prove this documentation in the medical record to support a supplier claim?

**Answer:** As noted in the policy, and in response to the questions above, the contemporaneous patient's medical record must support the claim.

# GLUCOSE MONITORS

## Updated Glucose Monitors and Supplies Physician Letter

The Glucose Monitors and Supplies letter to physicans has been updated. This letter provides guidance to physicians on Medicare's coverage and documentation requirements.

## Diabetic Testing Supplies (HCPCS A4253KX, A4253KS) Quarterly Results of Service Specific Prepayment Review

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from June 2015 through August 2015 are as follows:

The A4253KX review currently has an overall potential improper payment rate of 65% and the A4253KS review currently has an overall potential improper payment rate of 52%.

**The top reasons for denial were:**

- Testing logs or documentation indicating frequency of testing was not received.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Proof of Delivery (POD) was not received.
- Detailed Written Order (DWO) was not received.
- Documentation for refill requirements was not received.

For complete details, see Diabetic Testing Supplies (HCPCS A4253KX, A4253KS) Quarterly Results of Service Specific Prepayment Review.

# HOSPITAL BEDS

## Hospital Beds (HCPCS E0250) 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 E0250.

The E0250 review involved 106 claims, of which 78 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 77%.

**The top reasons for denial were:**

- The Detailed Written Order (DWO) is incomplete or missing elements.
- No detailed Written Order Prior to Delivery (WOPD) was received.
- The Proof of Delivery (POD) was invalid.
- The documentation submitted does not support the criteria for a fixed height bed.

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

# ICD-10 Claims Submission Alternatives for Providers Who Have Difficulties

## MLN Matters® Number: SE1522

### Provider Types Affected

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

### Provider Action Needed

This MLN Matters® Special Edition article offers physicians, providers, and suppliers information that will assist them in avoiding claims processing disruptions after implementation of International Classification of Diseases, Tenth Edition (ICD-10) on October 1, 2015. It provides information for providers who have difficulties submitting ICD-10 claims due to being unable to complete necessary systems changes or having issues with billing software, vendor(s), or clearinghouse(s).

### Background

For FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/ THROUGH dates (on institutional claims) on or after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use ICD-10 code sets adopted under HIPAA.

### ICD-10 Claims Submission Alternatives

If you have difficulties submitting ICD-10 claims due to being unable to complete the necessary systems changes or having issues with your billing software, vendor(s), or clearinghouse(s), the following claims submission alternatives are available:

- Free billing software;
- Provider internet portals;
- Direct Data Entry (DDE); and
- Paper claims.

Each claims submission alternative is discussed in more detail below.

**Please note that these claims submission alternatives REQUIRE THE USE OF ICD-10 code sets for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015.**

### FREE BILLING SOFTWARE

**Providers Who Submit Claims to MACs**

You may download the free billing software that the Centers for Medicare & Medicaid Services (CMS) A/B MACs offer on their web pages. The software has been updated to support ICD-10 codes and requires either a Network Service Vendor (NSV) or dial-up or both to transmit claims. The software download is free, but there may be fees associated with submitting claims through an NSV or dial-up. The MAC web pages also provide information about NSVs.

This billing software only works for submitting Fee-For-Service (FFS) claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors' ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

**Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service (on professional claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be rejected by Medicare.**

### Providers Who Submit Claims to DME MACs

DME suppliers may download the free billing software that CMS offers via the Common Electronic Data Interchange (CEDI) website. The software has been updated to support ICD-10 codes and requires NSV connectivity to transmit Medicare DME claims to CEDI. The software download is free, but there may be fees associated with submitting claims through an NSV. The list of approved NSVs and an NSV Frequently Asked Questions document is available at http://www.ngscedi.com/nsv on the CEDI website. You must also have a CEDI Trading Partner/Submitter ID to use the free billing software to submit claims to CEDI.

- If you currently do not have a CEDI Trading Partner ID (begins with A08, B08, C08, or D08) to submit claims directly to CEDI (for example, you submit claims through a clearinghouse or billing service), you will need to complete the necessary CEDI enrollment forms to obtain a CEDI Trading Partner ID.
- If you currently have a CEDI Trading Partner ID, you will use that to submit claims with the free billing software.

You can find CEDI enrollment forms at http://www.ngscedi.com/forms/formsindex.htm on the CEDI website. You should submit the forms to CEDI as soon as possible, but no later than September 15, 2015, to allow CEDI time to process your request and for any testing you might want to do prior to the October 1, 2015, ICD-10 implementation. You will also need to allow for any additional time to sign up and establish connectivity to CEDI through the NSV that you choose.

This billing software only works for submitting FFS claims to Medicare. It is intended to provide submitters with an ICD-10 compliant claims submission format; it does not provide coding assistance.

Information about the free billing software is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors' ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

**Please note that submitting electronic claims to Medicare using the free billing software does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service on or after October 1, 2015. Any claims containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected by Medicare.**

## PROVIDER INTERNET PORTALS

In some cases, you may be able to use your MAC's provider internet portal to submit ICD-10 compliant professional claims. All MACs offer the portals, and a subset of these MAC portals offer claims submission. Provider portal internet claim submission is not available for institutional or supplier claims.

Information about registering for access to provider internet portals is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors' ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

**Please note that claims submitted via our provider portal must contain ICD-10 codes for FROM dates of service on or after October 1, 2015. Those submitted containing ICD-9 codes for FROM dates of service on or after October 1, 2015, will be rejected through normal claims editing processes. ICD-9 codes will still be accepted for FROM dates prior to October 1, 2015.**

## DDE

Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. DDE requires a connectivity service provided by an external company to establish the connection.

Information about registering to submit claims via DDE and lists of DDE service vendors is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors' ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

**Please note that claims submitted via DDE must contain ICD-10 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015. Those submitted containing ICD-9 codes for dates of DISCHARGE/THROUGH dates on or after October 1, 2015, will be Returned to Provider (RTP).**

## PAPER CLAIMS

In limited situations, you may submit paper claims with ICD-10 codes to Medicare. To find more information on when you may submit paper claims, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCAWaiver.html on the CMS website. Please note that to submit paper claims, you must meet the requirements to qualify for a waiver of the Administrative Simplification Compliance Act (ASCA) provisions.

Information about submitting paper claims and ordering claim forms is available on each of the CMS Contractor websites. Please refer to the document that provides web page access to all Contractors titled Contractors' ICD-10 Claims Submission Alternatives Web Pages on the CMS website.

### Waivers Subject to MAC Evaluation

Providers must apply for and meet all of the following requirements to qualify for a waiver of the ASCA provisions:

- Your software vendor is not ICD-10 ready, and it will cause a financial hardship for you to switch to another vendor; or
- Your software is not ICD-10 ready, and it will cause a financial hardship for you to switch to new software; and
- Your MAC's provider internet portal does not support electronic claims submissions; and
- It would cause financial hardship for you to procure the services of a billing agent/clearinghouse.

It is the provider's responsibility to submit all of the following documentation to the MAC to establish the validity of a waiver request:

- A letter from the vendor stating that their software is not ICD-10 compliant; or
- Attestation from the provider stating that your software is not ready for ICD-10; and
- Attestation of provider financial hardship; and
- Acknowledgement that paper claims must be submitted in a machine scannable format.

If the MAC determines that the waiver request meets the criteria described above and proper documentation has been provided, the MAC will grant the waiver request.

### Corrective Action Plan (CAP)

A provider who qualifies for a waiver to submit paper claims will be placed on a CAP not to exceed 120 days and must submit a CAP detailing the steps, with associated timelines, being taken to become ICD-10 compliant.

**Please note that submitting paper claims to Medicare, even if approved for an ASCA waiver, does not change the requirement for ICD-10 compliant claims to be submitted for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015. Any paper claims containing ICD-9 codes for FROM dates of service (on professional and supplier claims) or dates of DISCHARGE/THROUGH dates (on institutional claims) on or after October 1, 2015, will be returned as unprocessable by Medicare.**

### Information and Resources

Visit the following web pages to find information and resources that will assist you in submitting ICD-10 codes to Medicare:

- General ICD-10-CM/PCS information: http://www.cms.gov/Medicare/Coding/ICD10/index.html;
- ICD-10 Fee-For-Service provider resources including claims processing and billing, coding, unspecified ICD-10-CM codes, home health provider information, NCDs and LCDs, testing and results, features and benefits, and calls and background: https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-for-Service-Provider-Resources.html;

- General Equivalence Mappings: http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html; and
- ICD-10 National Coverage Determinations: http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website.

### Additional Information

If you have any questions, please contact your MAC at their toll-free number. To find MAC toll-free numbers, please refer to the Review Contractor Interactive Map located at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/index.html on the CMS website.

## Claims Processing Guidance for Implementing ICD-10 – A Re-Issue of MM7492 – Fourth Revision

### MLN Matters® Number: SE1408 Revised

### Related Change Request (CR) #: 7492

### Effective Date: October 1, 2014

This article was revised on October 30, 2015, to add language to Table A on page 3 regarding Inpatient Psychiatric Facilities (IPFs) and Long Term Care Hospital (LTCH) PPS. All other information remains the same.

### Provider Types Affected

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

### Provider Action Needed

For dates of service on and after October 1, 2015, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2015. As a result of CR7492 (and related MLN Matters® Article MM7492), guidance was provided on processing certain claims for dates of service near the original October 1, 2013, implementation date for ICD-10. This article updates MM7492 to reflect the October 1, 2015, implementation date. Make sure your billing and coding staffs are aware of these changes.

### Key Points of SE1408

**General Reporting of ICD-10**

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to http://www.cms.gov/Medicare/Coding/ICD10/index.html for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

**General Claims Submissions Information**

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be Returned to Provider (RTP) as unprocessable. Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP all claims that are billed with both ICD-9 and ICD-10 diagnosis codes on the same claim. For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP all claims that are billed with both ICD-9 and ICD-10 procedure codes on the same claim. For claims with dates of service prior to October 1, 2015, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2015, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2015. Institutional claims containing ICD-10 codes for services prior to October 1, 2015, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2015, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

**Will the Centers for Medicare & Medicaid Services (CMS) allow for dual processing of ICD-9 and ICD-10 codes (accept and process both ICD-9 and ICD-10 codes for dates of service on and after October 1, 2015)?**

No, CMS will not allow for dual processing of ICD-9 and ICD-10 codes after ICD-10 implementation on October 1, 2015. Many providers and payers, including Medicare have already coded their systems to only allow ICD-10 codes beginning October 1, 2015. The scope of systems changes and testing needed to allow for dual processing would require significant resources and could not be accomplished by the October 1, 2015, implementation date. Should CMS allow for dual processing, it would force all entities with which we share data, including our trading partners, to also allow for dual processing. In addition, having a mix of ICD-9 and ICD-10 codes in the same year would have major ramifications for CMS quality, demonstration, and risk adjustment programs.

**Claims that Span the ICD-10 Implementation Date**

There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims. For example, the beneficiary is admitted as an inpatient in late September, 2015 and is discharged after October 1, 2015. Another example is a DME claim for monthly billing that spans between September and October, 2015 (that is, the monthly billing dates are September 15, 2015 – October 14, 2015). The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

### Table A – Institutional Providers

| Bill Type(s) | Facility Type/ Services | Claims Processing Requirement | Use FROM or THROUGH Date |
|---|---|---|---|
| 11X | Inpatient Hospitals (including TEFRA hospitals, Inpatient Prospective Payment System (PPS) hospitals and Critical Access Hospitals (CAHs) | If the hospital claim has a discharge and/or through date on or after 10/1/15, then the entire claim is billed using ICD-10. | THROUGH |

| Bill Type(s) | Facility Type/ Services | Claims Processing Requirement | Use FROM or THROUGH Date |
|---|---|---|---|
| 11X | Inpatient Psychiatric Facility (IPF) and Long Term Care Hospital (LTCH) PPS | *NOTE: If the hospital claim has a discharge and/orthrough date on or after 10/1/15, and a benefits exhaust occurrence code with a September 2015 date does not exist, the entire claim is billed using ICD-10. If a benefits exhaust occurrence code with a September 2015 date exists, the provider must split bill the claim using the benefits exhaust occurrence code date as the through date on the first claim and bill with ICD-9 codes. The subsequent claim is billed as a no pay claim with appropriate ICD-10 coding. | *See Note |
| 12X | Inpatient Part B Hospital Services | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 13X | Outpatient Hospital | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 14X | Non-patient Laboratory Services | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 18X | Swing Beds | If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10. | THROUGH |
| 21X | Skilled Nursing (Inpatient Part A) | If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/2015, then the entire claim is billed using ICD-10. | THROUGH |
| 22X | Skilled Nursing Facilities (Inpatient Part B) | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 23X | Skilled Nursing Facilities (Outpatient) | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |

| Bill Type(s) | Facility Type/ Services | Claims Processing Requirement | Use FROM or THROUGH Date |
|---|---|---|---|
| 32X | Home Health (Inpatient Part B) | Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2015, but require those claims to be submitted using ICD-10 codes. | THROUGH |
| 3X2 | Home Health – Request for Anticipated Payment (RAPs)* | *NOTE - RAPs can report either an ICD-9 code or anICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2015. | *See Note |
| 34X | Home Health – (Outpatient ) | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 71X | Rural Health Clinics | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 72X | End Stage Renal Disease (ESRD) | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 73X | Federally Qualified Health Clinics (prior to 4/1/10) | N/A – Always ICD-9 code set. | N/A |
| 74X | Outpatient Therapy | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 75X | Comprehensive Outpatient Rehab facilities | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 76X | Community Mental Health Clinics | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |

| Bill Type(s) | Facility Type/ Services | Claims Processing Requirement | Use FROM or THROUGH Date |
|---|---|---|---|
| 77X | Federally Qualified Health Clinics (effective 4/4/10) | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 81X | Hospice- Hospital | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 82X | Hospice – Non hospital | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |
| 83X | Hospice – Hospital Based | N/A | N/A |
| 85X | Critical Access Hospital | Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2015 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2015 and later. | FROM |

### Table B – Special Outpatient Claims Processing Circumstances

| Scenario | Claims Processing Requirement | Use FROM or THROUGH Date |
|---|---|---|
| 3-day /1-day Payment Window | Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2015, the claim must be billed with ICD-10 for those bundled outpatient services. | THROUGH |

### Table C – Professional Claims

| Type of Claim | Claims Processing Requirement | Use FROM or THROUGH Date |
|---|---|---|
| All anesthesia claims | Anesthesia procedures that begin on 9/30/2015 but end on 10/1/2015 are to be billed with ICD-9 diagnosis codes and use 9/30/2015 as both the FROM and THROUGH date. | FROM |

### Table D –Supplier Claims

| Supplier Type | Claims Processing Requirement | Use FROM or THROUGH/TO Date |
|---|---|---|
| DMEPOS | Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/2015 (i.e., the FROM date of service occurs prior to 10/1/2015 and the TO date of service occurs after 10/1/2015). | FROM |

### Additional Information

You may also want to review SE1239 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1239.pdf on the CMS website. SE1239 announces the revised ICD-10 implementation date of October 1, 2015.

You may also want to review SE1410 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1410.pdf on the CMS website.

## CEDI ICD-10 Front End Edits

CEDI suppliers, Trading Partners, billing services, clearinghouses and vendors must begin using ICD-10 diagnosis codes on production claims with from dates of service October 1, 2015, and after.

The following provides information on the CEDI front end edits related to ICD-10 billing that may be returned on a 999 acknowledgement transaction or a 277 Claims Acknowledgement (277CA).

ICD-10 Front End Acknowledgement testing can be done through the CEDI system at any time. This type of testing can assist with ensuring that your electronic claim transactions will not be impacted by any of these edits.

### 999 Acknowledgement Rejections:

- All X12 837P syntactical and semantic requirements currently in place for submitting claims ICD-9 codes still apply for ICD-10 codes and rejections are returned on your 999 acknowledgement transaction. For example, the diagnosis code qualifier must be present for each diagnosis code, and a second diagnosis code cannot be reported unless a primary diagnosis is reported.
- The X12 qualifier values for ICD-10 are different than those for ICD-9. For ICD-10 billing, the primary diagnosis code qualifier value is "ABK" and all subsequent ICD-10 diagnosis code qualifier values are "ABF".

### 277 Claims Acknowledgement (277CA) Rejections

| Rejection | Logic and Edit References |
|---|---|
| CSCC A7: "Acknowledgement /Rejected for Invalid Information…"<br><br>CSC 254: "Primary Diagnosis Code" | Logic: ICD-10 code is not a valid ICD-10 code or is not valid for the Date of Service reported<br><br>Edit References:<br>X222.226.2300.HIxx-2.050<br>Where "xx" = 01, 09, 10, 11, or 12<br>X222.226.2300.HIxx-2.090<br>Where "xx" = 01, 09, 10, 11, or 12 |
| CSCC A7: "Acknowledgement /Rejected for Invalid Information…"<br><br>CSC 255: "Diagnosis Code" | Logic: ICD-10 code is not a valid ICD-10 code or is not valid for the Date of Service reported<br><br>Edit References:<br>X222.226.2300.HIxx-2.040<br>Where "xx" = 02, 03, 04, 05, 06, 07, or 08<br>X222.226.2300.HIxx-2.080<br>Where "xx" = 02, 03, 04, 05, 06, 07, or 08 |

| Rejection | Logic and Edit References |
|---|---|
| CSCC A7: "Acknowledgement /Rejected for Invalid Information…"<br><br>CSC 511: "Invalid Character"<br><br>CSC 254: "Primary Diagnosis Code" | Logic: Diagnosis code must not contain a decimal<br><br>Edit Reference:<br>X222.226.2300.HIxx-2.110<br>Where "xx" = 01, 09, 10, 11, or 12 |
| CSCC A7: " Acknowledgement /Rejected for Invalid Information…"<br><br>CSC 511: "Invalid Character"<br><br>CSC 255: "Diagnosis Code" | Logic: Diagnosis code must not contain a decimal<br><br>Edit Reference:<br>X222.226.2300.HIxx-2.100<br>Where "xx" = 02, 03, 04, 05, 06, 07, or 08 |
| CSCC A7: "Acknowledgement /Rejected for Invalid Information…"<br><br>CSC 254: "Primary Diagnosis Code"<br><br>CSC 509: "E-Code" | Logic: ICD-10 codes that begins with letter "V", "W", "X", or "Y" are not allowed.<br><br>Edit Reference:<br>X222.226.2300.HI01-2.125 |
| CSCC A7: "Acknowledgement /Rejected for Invalid Information…"<br><br>CSC 255: "Diagnosis Codes" | Logic: Cannot have both ICD-9 and ICD-10 codes on the same claim. If principal diagnosis code is an ICD-9 code then subsequent diagnosis code must be an ICD-9 code.<br><br>Edit Reference:<br>X222.226.2300.HIxx-1.040<br>Where "xx" = 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, or 12 |
| CSCC A7: "Acknowledgement /Rejected for Invalid Information…"<br><br>CSC 255: "Diagnosis Codes" | Logic: Cannot have both ICD-9 and ICD-10 codes on the same claim. If principal diagnosis code is an ICD-10 code then subsequent diagnosis code must be an ICD-10 code.<br><br>Edit Reference:<br>X222.226.2300.HIxx-1.050<br>Where "xx" = 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, or 12 |

## ICD-9 or ICD-10 Correct Billing of Codes

Noridian has received questions on whether to bill ICD-9 or ICD-10 codes on Medicare claims when the dates of service for the claim span the months of September and October, 2015. CMS has provided guidance on this topic in Medicare Learning Network (MLN) Special Edition (SE) 1408.

This MLN article contains a table outlining how various types of claims are to be submitted, including DME claims. We encourage you to share this article with all billers and post this in the billing office for easy reference.

View the ICD-9 vs. ICD-10 Billing Guidelines Effective October 1.

## Diagnosis Codes that Require Fourth or More Digits

Below are the most commonly billed codes billed to Noridian from October 26 - November 13 that denied due to missing digits on electronic claims. When using diagnosis crosswalk tools, ensure the code has the correct number of digits as outlined in the detailed coding guidelines.

Reference coding manuals or the coding guidelines on the CMS website.

| Invalid ICD-10 Diagnosis Code | Missing Digit | Diagnosis Description |
|---|---|---|
| E11 | Fourth | Type 2 Diabetes Mellitus |
| G47.1 | Fifth | Hypersomnia |
| J45 | Fourth | Asthma |
| J45.3 | Fifth | Mild Persistent Asthma |
| J47 | Fourth | Bronchiectasis |
| J96.0 | Fifth | Acute Respiratory Failure |
| M19.9 | Fifth | Osteoarthritis, Unspecified Site |
| R131 | Fifth | Dysphagia |
| R26 | Fourth | Abnormalities of Gait and Mobility |
| R268 | Fifth | Other Abnormalities of Gait and Mobility |

## Electronic Claim Denials: Post ICD-10 Implementation

While ICD-10 was implemented on October 1, 2015, and the vast majority of claims are being submitted appropriately, below in the order of occurrence, are the most common reasons for front-end rejections of DME electronic claims. We have also listed reminders about these billing scenarios and ways to avoid denials.

1. Using an ICD-9 code for a date of service on/after October 1, 2015.
2. Using an ICD-10 code for a date of service prior to October 1, 2015.
3. Submitting both ICD-9 and ICD-10 diagnosis codes on the same claim.
4. Submitting a diagnosis code that does not have the required number of digits.

### When should I use an ICD-9 code versus an ICD-10 code?

Claims with a single date of service (D8 qualifier) where the date is prior to October 1, 2015, must contain only ICD-9 diagnosis codes.

Claims with a single date of service (D8 qualifier) where the date is on or after October 1, 2015, must contain only ICD-10 diagnosis codes.

Claims with a date range (RD8 qualifier) where the FROM date is prior to October 1, 2015, must only ICD-9 diagnosis codes.

Claims with a date range (RD8 qualifier) where the FROM date is on or after October 1, 2015, must contain only ICD-10 diagnosis codes.

### Can I use ICD-9 and ICD-10 codes on the same claim?

No. ICD-9 and ICD-10 codes cannot be submitted on the same claim. Claims requiring an ICD-9 code and claims requiring an ICD-10 code for the same beneficiary will need to be sent as separate claims.

### Diagnosis Codes that Require a Fifth or More Digits

Below are codes billed in October that denied due to missing digits. When using diagnosis crosswalk tools, you must still ensure that the code has the correct number of digits as outlined in the detailed coding guidelines. Reference your coding manuals or the coding guidelines on the CMS website.

- E116 Type I diabetes mellitus with other specified complications
- I678 Other specified cerebrovascular diseases
- I690 Sequelae of nontraumatic subarachnoid hemorrhage
- J4590 Asthma
- J960 Acute respiratory failure

- M199 Osteoarthritis, unspecified site
- R131 Dysphagia
- R268 Other abnormalities of gait and mobility
- S069X9 Unspecified Intracranial injury with loss of consciousness of unspecified duration
- S31 Open wound of abdomen, lower back, pelvis and external genitals

## ICD-10 Claims Processing and Remittance Advice Messages

Effective with the implementation of ICD-10 for dates of service on/after October 1, 2015, suppliers may see the below denials when invalid diagnosis codes are included on claims.

CEDI will be applying front-end edits to electronic claims to verify the validity of ICD-9 and ICD-10codes diagnosis codes. For information on CEDI reports relating to reporting of diagnosis codes, view the CEDI ICD-10 EDI Front-End Edits article published to "Latest Updates" on September 21, 2015.

Editing will be done through the claims processing system and will result in a claim denial on the Remittance Advice (RA). Suppliers may see the following RA remark codes for invalid diagnosis codes.

- M81 – Supplier is required to code to the highest level of specificity
- M76 – Missing/incomplete/invalid diagnosis or condition

**Note:** A missing diagnosis indicator of "9" for ICD-9 diagnosis codes or "0" for ICD-10 diagnosis codes in Item 21 on the CMS-1500 claim form may result in an M76 denial.

Most of these claims denials will be unprocessable; therefore, a corrected claim must be submitted. If the denial is not unprocessable, providers may be able to correct the diagnosis by requesting a reopening.

Although a claim may contain a valid diagnosis code, it can still deny for medical necessity because the diagnosis or procedure code is not covered per the Local Coverage Determination (LCD) or National Coverage Determination (NCD) coverage guidelines. These denials must be appealed, with documentation to support the covered diagnosis. Such denials can result in the below RA messages.

> **N115** - This decision was based on an LCD. An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.
>
> **N386** - This decision was based on an NCD. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.

**Disclaimer:** It is difficult to anticipate all of the ways that a claim may be denied, therefore, the above is only general guidance.

## ICD-10 News: Checking Your Medicare FFS Claim Status

With the recent transition to ICD-10, you may wonder how soon you will know whether your Medicare fee-for-service (FFS) claim was paid.

Generally speaking, Medicare FFS claims take several days to be processed and must also – by law – wait two weeks before payment is issued.

**You can check your Medicare FFS claim status by:**

1. **Interactive Voice Response (IVR):** IVR gives providers access to Medicare claims information through a toll-free telephone number. Visit your Medicare Administrative Contractor (MAC) website for information on the Provider Contact Center and IVR user guide.
2. **Customer Service Representative (CSR):** Visit your MAC website for information on the Provider Contact Center only if you are unable to access claims information via IVR.
3. **MAC portal:** Visit your MAC website for portal features and access.
4. **Direct Data Entry (DDE):** Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. Visit your MAC website for more information.

5. **ASC X12:** The ASC X12 Health Care Claim Status Request and Response (276/277) is a pair of electronic transactions you can use to request the status of claims (via the 276) and receive a response (via the 277). Visit your MAC website for more information.

### Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org for the latest news and resources, including the ICD-10 Quick Start Guide. Sign up for CMS ICD-10 Email Updates and follow us on Twitter.

**Source:** CMSLISTS Email Update dated October 20, 2015

## Dear Physician Letter – ICD-10

The DME Medical Directors have provided a letter that suppliers may use to remind physicians of the ICD-10 requirement, beginning October 1, 2015. For certain DMEPOS items ordered for Medicare beneficiaries, only designated ICD-10 diagnosis codes will be allowable within the claims processing system for proper reimbursement. Not only must the appropriate ICD-10 diagnosis code, with the maximum level of specificity, be provided to the DMEPOS supplier for claim submission; that ICD-10 diagnosis code must be supported and documented appropriately within the patient's medical record.

## ICD-10 is One Week Out

ICD-10: One Week Out

In one week, the U.S. health care system will start using the International Classification of Diseases, 10th Revision. This is a huge moment because ICD-10 will help doctors and other health care providers better:

- Define patients' clinical status and treat their complex medical conditions.
- Coordinate care among providers.
- Support new payment methods that drive quality of care.

As we come to October 1st, CMS wants to assure the medical community that we've tested and retested our systems, and we're prepared to solve problems that may come up.

**Because we know this is a major transition, we'll be:**

- Monitoring the transition in real time.
- Watching our systems.
- Addressing any issues that come to the ICD-10 Coordination Center.

**We'll also be supporting you in four ways:**

1. If you need general ICD-10 information, we have many free resources at our Road to 10 webpage and on gov/ICD10 that can help, such as the ICD-10 quick start guide, customized ICD-10 action plans, videos, and Frequently Asked Questions.
2. Your first line for help for Medicare claims questions is to contact your Medicare Administrative Contractor. They'll offer their regular customer service support and respond quickly. You can find MAC contact information here.
3. You can e-mail our ICD-10 Coordination Center, and we'll respond to your questions.
4. You can contact me, the ICD-10 Ombudsman. I'll be an impartial advocate for providers, focused on understanding and resolving your concerns.

We've been working to help you move to ICD-10 by offering resources and flexibility, but if you aren't ready for the transition, you still have options that will enable you to continue to provide care and be paid for your services. We recommend that you check with other payers to learn about their available claims submission alternatives.

The Road to 10 countdown clock highlights how close we are to this important milestone. If you haven't yet started to transition, it is doable, and we encourage you to start today.

**Source:** CMSLISTS Email Update dated September 24, 2015

# ICD-10 News: Assess How ICD-10 Will Affect Your Practice

## Get Ready Now: Assess How ICD-10 Will Affect Your Practice

**With ICD-10 just 30 days away, now is the time to get ready. You can make sure your practice is prepared by following the ABCs of ICD-10:**

- **A**ssess how ICD-10 will affect your practice and make a plan
- **B**e sure your systems are ready
- **C**ontact your vendors

Today, we'll explore "A" – "Assess how ICD-10 will affect your practice."

**As part of assessing how ICD-10 affects your practice, you should find out if you need:**

Access to ICD-10 codes – You can find codes from a variety of sources, including:

- Code books
- CD/DVD and other digital media
- Online (e.g., go to cms.gov/ICD10 and select "2016 ICD-10-CM and GEMS" to download 2016 Code Tables and Index)
- Practice management systems
- Electronic health record (EHR) products
- Free and low-cost smart phone apps
- CMS ICD-10 Code Lookup
- Coding Conversion Tool

Clearinghouse services – Some providers who are not ready could benefit from contracting with a clearinghouse to submit claims.

- Clearinghouses can help by:
  - Identifying problems that lead to claims being rejected
  - Providing guidance about how to fix rejected claims (e.g., more or different data need to be included)
- Clearinghouses cannot help you code in ICD-10 codes unless they offer third-party billing/coding services.

Clinical documentation and coding training

- Train staff on ICD-10 fundamentals using the wealth of free resources from CMS, which include the ICD-10 website, Road to 10, Email Updates, National Provider Calls, and webinars. Free resources are also available from:
  - Medical societies, health care professional associations
  - Hospitals, health systems, health plans, vendors
- Training for clinical staff—e.g., physicians, nurse practitioners, physician assistants, registered nurses—should focus on documentation, new coding concepts captured in ICD-10.
- Training for coding and administrative staff—e.g., coders, billers, practice managers—should focus on ICD-10 fundamentals.

New forms – It is crucial to update hard-copy and electronic forms (e.g., superbills, CMS 1500 forms).

Systems upgrades – Double check that you've identified all systems that use ICD codes and need upgrades (e.g., practice management systems, electronic health record (EHR) products).

- Call your vendors to confirm the ICD-10 readiness of your practice's systems
- Confirm that the health plans, clearinghouses, and third-party billing services you work with are ICD-10 ready

- Ask vendors, health plans, clearinghouses, and third-party billers about testing opportunities
- Transition costs for small medical practices could be substantially lower than projected earlier:
  - Many EHR vendors are including ICD-10 in their systems or upgrades—at little or no cost to their customers
  - Software and systems costs for ICD-10 could be minimal for many providers

### Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org for the latest news and resources, including the ICD-10 Quick Start Guide. Sign up for CMS ICD-10 Email Updates and follow us on Twitter.

## ICD-10 News: Be Sure Your Systems Are Ready

### Get Ready Now: Be Sure Your Systems Are Ready

**With ICD-10 less than 30 days away, now is the time to get ready. You can make sure your practice is prepared by following the ABCs of ICD-10:**

- **A**ssess how ICD-10 will affect your practice and make a plan
- **B**e sure your systems are ready
- **C**ontact your vendors

Today, we'll explore "B" – "Be sure your systems are ready."

**You'll want to verify that you can:**

- Generate and submit claims
- Schedule outpatient procedures
- Perform eligibility and benefits verifications
- Prepare to submit quality data
- Schedule office visits
- Update patient histories and encounters
- Code a patient encounter

### Testing

The best way to ensure your systems are ready is to test. Focus on your highest-risk scenarios like claims processing and the diagnoses you see the most often as you test any system that stores, processes, sends, receives, or reports diagnosis code information.

**You can test:**

- Inside your practice
- With clearinghouses, billing services, and health plans

And you can test even if your system is not ready. If you don't have an ICD-10-ready system installed yet, you can still conduct meaningful testing. One good way to start is to look at ICD-10 codes for the top 10 conditions you see:

1. Consider the volume of conditions and those that account for most of your revenue.
2. Look at recent medical records for patients with these conditions and try coding them in ICD-10 for practice. Do the records include the documentation needed to supply select the correct ICD-10 code(s)?
3. Use any cases of insufficient documentation to create a checklist for clinicians to consult.

All Medicare fee-for-service (FFS) providers who submit electronic claims can conduct acknowledgement testing with their Medicare Administrative Contractor (MAC) at any time until September 30:

- You do not need to register to participate

- You may submit an unlimited number of claims
- You can acknowledgement test claims directly or through a clearinghouse or billing agency

**To submit claims for testing, you must use:**

- Current dates of service
- The test indicator "T" in the Interchange Control Structure (ISA) 15 field

For more information about testing your systems, check out the ICD-10 Testing Infographic.

### Alternate Claims Submission Methods

- Explore alternate ways to submit claims to health plans if you think your systems will not be ready for ICD-10 by October 1. For Medicare providers, options include:
  - Free billing software available from every MAC website
  - Part B claims submission by online provider portal (in about ½ of MAC jurisdictions)
  - Paper claims for providers who meet Administrative Simplification Compliance Act Waiver requirements
  - Each of these options requires you to code in ICD-10
- Ask other health plans you work with about the options they offer

### Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org for the latest news and resources, including the ICD-10 Quick Start Guide. Sign up for CMS ICD-10 Email Updates and follow us on Twitter.

## ICD-10 News: Contact Your Software Vendors, Clearinghouses, and Billing Services

### Get Ready Now: Contact Your Software Vendors, Clearinghouses, and Billing Services

**With ICD-10 less than 30 days away, now is the time to get ready. You can make sure your practice is prepared by following the ABCs of ICD-10:**

- **A**ssess how ICD-10 will affect your practice and make a plan
- **B**e sure your systems are ready
- **C**ontact your vendors

Today, we'll explore "C" – "Contact your vendors."

If you aren't sure your systems are ready for ICD-10, contact your vendors and other business trading partners.

### Ask about testing opportunities

- Test with vendors, clearinghouses, billing services, and health plans to:
  - Verify that you can submit, receive, and process data with ICD-10 codes
  - Understand how ICD-10 updates affect the transactions you submit
  - Identify and address specific issues before October 1
- Check for testing opportunities at the website of the Cooperative Exchange, an association of clearinghouses.

Confirm vendors and products are ICD-10-ready

- Call your vendors to confirm the ICD-10 readiness of your practice's systems
  - Confirm that the health plans, clearinghouses, and third-party billing services you work with are ICD-10 ready

  - Ask vendors, health plans, clearinghouses, and third-party billers about testing opportunities
  - Many EHR vendors are including ICD-10 in their systems or upgrades—at little or no cost to their customers
- You can use forms available in the Road to 10's Template Library to guide discussions with vendors, health plans, clearinghouses, and billing services
- Double check that you've identified all systems that use ICD codes—e.g., practice management systems, claims submission systems, electronic health record (EHR) products—when contacting vendors
- Update contracts with vendors and health plans as needed

### Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org for the latest news and resources, including the ICD-10 Quick Start Guide. Sign up for CMS ICD-10 Email Updates and follow us on Twitter.

## Use ICD-10 Now – Here's How

On October 1 the United States health care community transitioned to ICD-10. CMS wants providers to be successful in using ICD-10 and remains committed to working with industry on the transition.

To give providers a quick reference, we've posted the Use ICD-10 Now infographic below on our website. (To access the links in the infographic, please use the version on the CMS website.)

### Coding Claims: When to Use ICD-10 versus ICD-9

Use of ICD-10 versus ICD-9 on claims is based on dates of service—not on dates that claims are submitted.

- For dates of service before October 1, 2015, use ICD-9 codes.
- For dates of service on or after October 1, 2015, use ICD-10 codes.

For example, if you submit a claim for services provided on September 30, 2015, use ICD-9, even if you are submitting the claim in October 2015 or beyond.

For hospital inpatient claims, use date of discharge rather than date of service to determine whether to code in ICD-10 or ICD-9.

### Important Note About Physician's Orders

For orders written with ICD-9 codes before October 1, CMS is not requiring the ordering provider to rewrite the original order with the appropriate ICD-10 code for lab, radiology services, or any other services. For more see the new Physician's Orders FAQ 12625.

### Splitting Claims

Many health plans require claims with dates of service spanning October 1 to be split into two claims, one with ICD-9 and the other with ICD-10 codes.

A Medicare fee-for-service (FFS) claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will not pay claims containing both ICD-9 and ICD-10 codes. CMS has issued guidance for providers dealing with claims spanning the compliance date.

### Accessing Codes

See the ICD-10 Coding Resources fact sheet to find out about accessing ICD-10 codes, ICD-9/ICD-10 mappings, and clinical documentation tips.

### Other Resources

- Find the latest resources at the official CMS ICD-10 website.
- Visit Roadto10.org to build a customizable action plan, and to see common codes, documentation tips and clinical scenarios for your specialty.
- Find additional ICD-10 resources at low or no cost through medical and trade associations.

# ICD-10

### Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org for the latest news and resources, including the ICD-10 Quick Start Guide. Sign up for CMS ICD-10 Email Updates and follow us on Twitter.

**Source:** CMSLISTS Email Update dated October 9, 2015

# IMMUNOSUPPRESSIVE DRUGS

## Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Service Specific Prepayment Review

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

The J7507 review currently has an overall potential improper payment rate of 31%, the J7517 review currently has an overall potential improper payment rate of 35%, the J7518 review currently has an overall potential improper payment rate of 32% and the J7520 review currently has an overall potential improper payment rate of 35%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Refill request was not received.
- Proof of Delivery (POD) was incomplete, missing elements or not received.
- Detailed Written Order (DWO) was not received.

For complete details, see Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Service Specific Prepayment Review.

## Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Final Edit Effectiveness Results of Service Specific Prepayment Review

The final edit effectiveness results from the Jurisdiction D Medical Review Department from March 2015 through August 2015 are as follows:

The J7507 review currently has an overall potential improper payment rate of 60%, the J7517 review currently has an overall potential improper payment rate of 64%, the J7518 review currently has an overall potential improper payment rate of 56% and the J7520 review currently has an overall potential improper payment rate of 64%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No refill request was submitted.
- No Proof of Delivery (POD) was submitted.
- The order was incomplete or missing elements.

For complete details, see Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Final Edit Effectiveness Results of Service Specific Prepayment Review.

## LCD and Policy Article Summary for October 1, 2015 – Drafts Released to Final

**The following two draft Local Coverage Determinations and Policy Articles have been finalized:**

- Bowel Management Devices
- External Infusion Pumps

Each of these medical policies will be effective for claims with dates of service on or after October 1, 2015. The notice period start date is October 1, 2015 and the notice period end date is November 30, 2015.

### Bowel Management Devices

**LCD and Policy Article**

**Revision Effective Date: 12/01/2015**

**Draft LCD promoted to final**

### External Infusion Pumps

**LCD**

**Revision Effective Date: 12/01/2015**

**Draft LCD promoted to final**

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Criteria for reimbursement of intravenous inotropic medication
Added: Denial for Compound Drugs NOC Q9977
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Instructions for Q9977

Policy Article
Revision Effective Date: 12/01/2015
Draft Policy Article promoted to final
CODING GUIDELINES:
Added: Q9977 (Compounded drug NOC)

Please review each entire LCD and related Policy Article for coverage, coding and documentation requirements. Also review the Response to Comments Summary attached to each LCD.

## LCD Revisions Summary for October 8, 2015

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) that have been revised and posted. The policies included are Orthopedic Footwear, Osteogenesis Stimulators and Wheelchair Seating. Please review the entire LCD for complete information.

### Orthopedic Footwear

**LCD**

**Revision Effective: 10/01/2015**

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY

Added: Inadvertently omitted ICD10's subsequent visit

### Osteogenesis Stimulators

**LCD**

**Revision Effective Date: 10/01/2015**

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: References to ICD-10 Codes

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:

Deleted: ICD-10 Codes

### Wheelchair Seating

**LCD**

**Revision Effective: 10/01/2015**

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY

Added: Inadvertently omitted ICD10s; G and Q codes, subsequent visit and sequela

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

## LCD and Policy Article Summary for October 15, 2015 – Drafts Released to Final

Draft Pneumatic Compression Devices Local Coverage Determination and Policy Article has been finalized.

The medical policy will be effective for claims with dates of service on or after December 1, 2015. The notice period start date is October 15, 2015, and the notice period end date is November 30, 2015.

### Pneumatic Compression Devices

**LCD**

**Revision Effective Date: 12/01/2015**

**Draft Released to Final**

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Explicit statement on E0675 non-coverage
Added: E0676 benefit exclusion reference in related Policy Article
Revised: Requirements for Four-Week Trial for Lymphedema
Revised: Requirements for Six-Month Trial for Chronic Venous Insufficiency
Revised: E0652 requirements
HCPCS CODES AND MODIFIERS:
Added: E0675 and E0676
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS
Revised: Requirements for E0652
Added: E0675 to ACA 6407 requirements table

### Policy Article

**Revision Effective Date: 12/01/2015**

**Draft Released to Final**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Prevention of Venous Thrombolism exclusion from coverage
Added: Statutorily denial language for E0676
Added: E0675 to ACA 6407 requirements table
CODING GUIDELINES:
Added: Coding instructions for Sleeves E0656 and E0657
Added: Coding instructions for E0675
Added: E0675 to the Coding Verification Review

Please review the entire LCD and related Policy Article for coverage, coding and documentation requirements. Also review the Response to Comments Summary attached to the LCD.

## LCD and Policy Article Revisions Summary for October 22, 2015

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

### Speech Generating Devices

**LCD**

**Revision Effective Date: 07/29/2015 (October 2015 Publication)**

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: SGD definitional language from NCD 50.1
Added: Capability to download updates
Added: Gleason Act language for eye gaze accessories
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Documentation requirement for SGD and accessories

### Policy Article

**Revision Effective Date: 07/29/2015 (October 2015 Publication)**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: SGD definitional language from NCD 50.1
Added: Non-coverage statements from NCD 50.1
CODING GUIDELINES:
Added: Description of HCPCS Code A4601
Added: Definitions of SGD accessories and examples

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



## Denial for PMD Claim from a Supplier of DMEPOS When Ordered By a Non-Authorized Provider – Revised

### MLN Matters® Number: MM8239 Revised
### Related Change Request (CR) #: CR 8239
### Related CR Release Date: November 6, 2013
### Effective Date: April 1, 2014
### Related CR Transmittal #: R1305OTN
### Implementation Date: April 7, 2014

This article was revised on September 24, 2015, to change the link to the list of providers authorized to order a PMD on page 5. That link was changed to https://data.cms.gov on the CMS website. For a complete list of any other changes to this article, please refer to the Document History Section. All other information remains the same.

### Provider Types Affected

This MLN Matters® Article is intended for suppliers of Durable Medical Equipment (DME) who submit claims to DME Medicare Administrative Contractors (DME/MACs) for Power Mobility Devices (PMDs) provided to Medicare beneficiaries.

### Provider Action Needed

Change Request (CR) 8239 instructs Medicare contractors and system maintainers to implement edits to deny claims for certain PMDs if the ordering/referring provider is not on Medicare's list of providers eligible to order/refer these PMDs.

Make sure that your billing staffs are aware of these requirements and you do not order if you are not an authorized provider. Suppliers are required to ascertain that the provider is authorized to order a PMD. A denial of the claim will be issued if the provider is not of an authorized specialty to order a PMD.

## Background

Section 302(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), added Section 1834(a)(1)(E)(iv) to the Act which provides that payment may not be made for a covered item consisting of a motorized or power wheelchair unless a physician (as defined in section 1861(r)(1) of the Act), or a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) (as these terms are defined in Section 1861(aa)(5) of the Act) has conducted a face-to-face examination of the beneficiary and written a prescription for the item. This purpose of CR 8239 is to create an edit to deny any Durable Medical, Orthotics, Prosthetics, and Supplies (DMEPOS) claims where the ordering/prescribing provider is not an eligible provider (physician, PA, NP, or CNS).

The following are the policies/definitions that impact Medicare allowances for PMDs:

1. Social Security Act Section 1834(a)(1)(E)(iv) standards for power wheelchairs;

- Effective on the date of the enactment of this subparagraph in the case of a covered item consisting of a motorized or power wheelchair for an individual, payment may not be made for such covered item unless a physician (as defined in Section 1861(r)(1)), a PA, NP or CNS (as those terms are defined in Section 1861(aa)(5)) has conducted a face-to-face examination of the individual and written a prescription for the item.

2. Social Security Act Section 1861(r)(1)

- The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)).

3. Social Security Act Section 1861(aa)(5)

- The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a PA or NP who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.
- The term "clinical nurse specialist" means, for purposes of this title, an individual who is a registered nurse and is licensed to practice nursing in the State in which the CNS services are performed; and holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

4. Based on 42 CFR Part 410.38(c), the following definitions apply: PMD means a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning) or a power-operated vehicle (a three or four-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

## Key Points of CR8239

The list of specified covered, PMD items: HCPCS Code and Description includes the following:

**K0800-K0808 and K0812:** ALL POWER OPERATED VEHICLES

**K0813-K0891, K0898:** POWER WHEELCHAIRS , and

**K0013:** CUSTOM MOTORIZED/ POWER WHEELCHAIR BASE.

The list of authorized physician specialties and their corresponding CMS specialty code in Provider Enrollment, Chain, and Ownership System (PECOS) is as follows:

## Medicare PECOS

| CODE | APPROVED PHYSICAN SPECIALTIES |
|---|---|
| 14 | NEUROSURGERY |
| 16 | OBSTETRICS/GYNECOLOGY |
| 17 | HOSPICE/PALLIATIVE CARE |
| 18 | OPHTHALMOLOGY |
| 20 | ORTHOPEDIC SURGERY |
| 21 | CARDIAC ELECTROPHYSIOLOGY |
| 22 | PATHOLOGY |
| 23 | SPORTS MEDICINE |
| 24 | PLASTIC AND RECONSTRUCTIVE SURGERY |
| 25 | PHYSICAL MEDICINE AND REHABILITATION |
| 26 | PSYCHIATRY |
| 27 | GERIATRIC PSYCHIATRY |
| 28 | COLORECTAL SURGERY (PROCTOLOGY) |
| 29 | PULMONARY DISEASE |
| 30 | DIAGNOSTIC RADIOLOGY |
| 33 | THORACIC SURGERY |
| 34 | UROLOGY |
| 36 | NUCLEAR MEDICINE |
| 37 | PEDIATRIC MEDICINE |
| 38 | GERIATRIC MEDICINE |
| 39 | NEPHROLOGY |
| 40 | HAND SURGERY |
| 44 | INFECTIOUS DISEASE |
| 46 | ENDOCRINOLOGY |
| 66 | RHEUMATOLOGY |
| 72 | PAIN MANAGEMENT |
| 76 | PERIPHERAL VASCULAR DISEASE |
| 77 | VASCULAR SURGERY |
| 78 | CARDIAC SURGERY |
| 79 | ADDICTION MEDICINE |
| 81 | CRITICAL CARE (INTENSIVISTS) |
| 82 | HEMATOLOGY |
| 83 | HEMATOLOGY/ONCOLOGY |
| 84 | PREVENTATIVE MEDICINE |
| 85 | MAXILLOFACIAL SURGERY |
| 86 | NEUROPSYCHIATRY |
| 90 | MEDICAL ONCOLOGY |
| 91 | SURGICAL ONCOLOGY |
| 92 | RADIATION ONCOLOGY |

| CODE | APPROVED PHYSICAN SPECIALTIES |
|---|---|
| **93** | EMERGENCY MEDICINE |
| **94** | INTERVENTIONAL RADIOLOGY |
| **98** | GYNECOLOGICAL ONCOLOGY |
| **C0** | SLEEP LABORATORY/MEDICINE |

The list of authorized non-physician specialties and their corresponding CMS specialty code in PECOS is as follows:

| CODE | APPROVED NON-PHYSICIAN SPECIALTY |
|---|---|
| 50 | NURSE PRACTITIONER |
| 89 | CLINICAL NURSE SPECIALIST |
| 97 | PHYSICIAN ASSISTANT |

Suppliers are required to ascertain that the provider is authorized to order a PMD. A list of providers authorized to order a PMD can be accessed (beginning April 2014) at https://data.cms.gov on the CMS website.

A denial of the claim will be issued if the provider is not on the PECOS list. Be aware that allof the criteria for coverage of PMDs must be met.

When a claim for a relevant PMD is denied because the ordering/referring provider was ineligible to place the order, Medicare will use the a Claim Adjustment Reason Code of 183 (The Referring Provider is not eligible to refer the service billed) and a Remittance Advice Remarks Code of N574 (Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer).

### Additional Information

The official instruction, CR 8239, issued to your DME/MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1305OTN.pdf on the CMS website.

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

For a look at face-to-face requirements and a checklist you may review SE1112, "Power Mobility Device Face-to-Face Examination Checklist" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1112.pdf on the CMS website.

## PMD Detailed Product Descriptions and Manual Wheelchair Orders

It is important for suppliers to ensure the quantity of items and accessories are clearly reported on the Detailed Product Descriptions (DPDs) and Written Orders Prior to Delivery (WOPDs).

During recent complex medical review of claims, Advance Determination of Medicare Coverage (ADMC) requests and Prior Authorization Requests (PARs) it was found that DPDs and WOPDs are often lacking sufficient detail to meet Medicare requirements for power mobility devices (PMDs) and manual wheelchairs. The DPD and WOPD must comply with the requirements for a Detailed Written Order (DWO) as outlined in the Supplier Manual Chapter 3 and the Centers for Medicare & Medicaid Services' (CMS') Internet Only Manual (IOM), Program Integrity Manual (PIM) 100-08, Chapter 5, Section 5.2.3.

**A DWO must contain:**

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)

- The prescribing practitioner's National Provider Identification (NPI)
- The signature of the ordering practitioner
- Signature date

For manual and power mobility bases it is important that the detailed description in the written order clearly indicate the item(s) being requested. This may be done by providing either a narrative description or a brand name/model number for each item being ordered. Regardless of the form of the description, there must be sufficient detail to identify the item(s) in order to determine that the item(s) dispended is properly coded.

**In addition, for items provided on a periodic basis the written order must include:**

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of administration
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

Periodic items provided may include wheelchair accessory and option components such as elevating leg rests, it is important to assure the quantity of these periodically provided items are defined on the DPD and/or WOPD.

## Reminders

- The DWO must be available upon request.
- A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the prescription but must be corroborated by information contained in the medical record.
- Many DME items have additional requirements per Section 6407 of the Affordable Care Act.

## Resources

- Local Coverage Determination (L33788) and Policy Article (A52497) for Manual Wheelchair Bases
- Local Coverage Determination (L33789) and Policy Article (A52498) for Power Mobility Devices
- Supplier Manual
- IOM, Program Integrity Manual, Chapter 5, Section 2
- MLN Matters: MM8304

## NEUBILIZERS

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

The quarterly edit effectiveness, from the Jurisdiction D Medical Review Department from April 2015 through June 2015 are as follows:

The J7605 review currently has an overall potential improper payment rate of 52% and the J7626 review currently has an overall 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.
- Office notes or medical records were not received.
- Proof of Delivery (POD) was not received.
- Documentation for refill requirements was not received.

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

## NEGATIVE PRESSURE WOUND THERAPY

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

The quarterly edit effectiveness results from the Jurisdiction D from April 2015 through July 2015 are as follows:

The E2402 has an overall potential improper payment rate of 74%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No office notes or medical records were received.
- The signature requirements were not met.
- The documentation submitted does not include a statement from the treating physician describing the initial condition of the wound and efforts to address all aspects of wound care.

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

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

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

The L0648 has an overall potential improper payment rate of 77% and the L0650 has an overall potential improper payment rate of 81%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No documentation was submitted to support coverage criteria.
- No Proof of Delivery (POD) was submitted or it was invalid.
- No office notes or medical records were provided.
- No documentation was submitted to support the reason for replacement.

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

## Lower Limb Prostheses – Draft Policy DL33787

### Joint DME MAC Publication

On November 02, 2015, CMS announced the convening of an inter-agency panel to address clinical questions associated with the provision of lower limb prostheses. The DME MACs are delaying finalization of the draft Lower Limb Prostheses LCD (DL33787) pending the final report of the panel.

Additional information is available on the CMS website.

## DME on Demand – Orthosis: Repairs and Replacements

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

**This session will include:**

- Repairs
  - Repairs – Supplier Records
  - Repairs – Physician Records
  - Parts
  - Labor
  - Replacements
  - L2999
  - Resources

### Viewing Presentation

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

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

# ORTHOTICS AND PROSTHETICS

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

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from March 2015 through June 2015 are as follows:

The L1833 review currently has an overall potential improper payment rate of 97%.

**The top reasons for denial were:**

- Documentation submitted does not support knee instability or that the beneficiary is ambulatory.
- Invalid or missing diagnosis code.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Documentation submitted does not support the medical necessity for the item requested.

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

# OSTEOGENESIS STIMULATORS

## Osteogenesis Stimulator Policy Revision FAQs

**Question 1:** Why have the diagnosis codes been removed from the revised policy?

**Answer:** The ICD-9 to ICD-10 cross-walk resulted in a policy that was very long and unwieldy.

The cross-walked policy was also lacking diagnosis codes for "subsequent encounters". The National Coverage Determination (NCD) for osteogenesis stimulators does not contain any diagnosis codes, and the medical directors have adopted the NCD's narrative format in this revision.

**Question 2:** Do we still have to submit the applicable diagnosis codes on the claims?

**Answer:** Yes, it is a claim processing system requirement that a diagnosis code(s) must be included on all claims.

**Question 3:** Do we still need to submit a Certificate of Medical Necessity (CMN) with the initial claim?

**Answer:** Yes. The removal of diagnosis codes from the Local Coverage Determination (LCD) does not change the requirement to submit a properly completed CMN for these items.

**Question 4:** What diagnosis code(s) should the physician/qualified provider use on the CMN?

**Answer:** The physician/provider should use an ICD-10 code that is applicable to the particular beneficiary's medical condition. An ICD-10 diagnosis code is not used to determine reimbursement. During a claim review, information contained in the contemporaneous medical record is what is used to justify that the required payment rules are met.

**Question 5:** With the removal of the ICD-10 diagnosis codes, has any of the coverage criteria for osteogenesis stimulators changed?

**Answer:** No. Coverage criteria for osteogenesis stimulators remains unchanged.

# OVERPAYMENTS AND REFUNDS

## Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

**Source:** Transmittal 50, Change Request 3274, dated July 30, 2004

# OXYGEN

## Oxygen Certificate of Medical Necessity Form Revision for ICD-10

A new revision to the Certificate of Medical Necessity (CMN) form 484 – OXYGEN is now available on the CMS Forms List. The form was updated to improve the format of the physician's signature field. Use of the new Oxygen CMN is required for all claims for services provided on or after October 1, 2015 and suppliers can use the new form before the October 1 deadline.

Several other revised CMNs and DME Information Forms (DIFS) were previously posted to the CMS website in preparation for the implementation of ICD-10. Noridian will maintain both old and new forms on our website due to the timely filing period for claims of one year from the date of service.

Beginning with dates of service on/after October 1, 2015, use of these new forms will be mandatory for all claims which require Initial, Revised or Recertification documents. If a CMN or DIF is already on file, a new one is not required for the sole purpose of updating for these revisions or to add an ICD-10 diagnosis code to a CMN or DIF.

For additional information about CMNs and DIFS, refer to the DME MAC Jurisdiction D Supplier Manual, Chapter 4. Refer to our news article CMN and DIF Revision for ICD-10, published on June 29, 2105, for additional information.

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

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

The E1390 review involved 2,885 claims which has an overall potential improper payment rate of 52%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Documentation received does not support alternative treatment.
- Documentation received does not support the diagnosis.
- Documentation received does not support that the patient was in a chronic stable state at the time of the study.

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

# OXYGEN

## Oxygen (E1390) Quarterly Results of Documentation Compliance Review

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from June 2015 through August 2015 are as follows:

The E1390 review currently has an overall potential improper payment rate of 25%.

**The top reasons for denial were:**

- No documentation was received in respose to the Additional Documentation Request (ADR) letter.
- No documentation indicating there was an office visit within 30 days.
- The proof of delivery (POD) was dated prior to the date of service on the claim.
- The initial evaluation is great than or equal to 31 days from the initial date on the Certificate of Medical Necessity (CMN).

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

# PNEUMATIC COMPRESSION DEVICES

## Response to Comments to Accompany LCD for Pneumatic Compression Devices

1. Comment: Some commenters noted that the LCD should provide coverage for pneumatic compression devices (PCDs) to include those for peripheral arterial disease (PAD). Other commenters proposed limited PCD coverage for PAD.

   **Response:** The medical directors disagree. When the DME Contractor Medical Directors published the Proposed LCD for PCDs in 2011, there had been a period of several years when we had regularly received requests for coverage of PCDs for PAD from a number of those treating these conditions, suggesting the technology and its acceptance had significantly advanced and was becoming more generally accepted. Many at the DME Open Public Meeting in August 2011 and in multiple written comments supported this position. Several commenters took the position that the LCD should include coverage of PCDs for all PAD, and not be restricted to those who would otherwise qualify for a surgery but were medically ineligible. This final policy does not allow for coverage of PCDs for PAD of any severity. In more closely and serially reviewing the statements and guidelines from nearly all of the major cardiovascular and surgical societies, support for the use of this technology is not found, even for limited use. For this reason we are not at this time adding routine coverage for PCDs for PAD.

   Continuing literature searches since the date of the draft release have shown no long-term studies supporting that outcomes using a PCD are comparable to the accepted standard of using a surgical revascularization where possible and no major cardiovascular or surgical societies have adopted guidelines taking this position. We received limited journal copies, anecdotal case-reports and brief series information to support the use of this technology as a temporizing or supportive measure for those with advanced disease who are otherwise ineligible for surgery, but here as well, there are no sizeable, long-term studies of efficacy. The medical directors extensively again reviewed all submitted literature as well as coverage decisions by major agencies, health service research entities and insurers (see in the LCD under Sources of Information and Basis for Decision). Of these, only one, from Ireland's Health Information and Quality Authority takes a position supporting any coverage, and that is equivocal, indicating "...more research is needed to confirm...a potentially beneficial treatment for people at risk of amputation who are not candidates for revascularization...remains unproven." After this reassessment, we have concluded it is not reasonable and necessary to add coverage of arterial compression devices (E0675) at this time.

2. Multiple commenters suggested diagnostic findings and tests that in their opinion could confirm eligible beneficiaries for PCDs for PAD as a possible alternative to attestation that the beneficiary would otherwise be a candidate for surgery.

   **Response:** There was little consistency to these recommendations. Had we pursued coverage of arterial compression at this time, we would have needed to continue the "otherwise be a candidate for surgery" criterion. Currently, there is no consensus on the usefulness of available diagnostic tests to demonstrate the predictive value of arterial PCD.

3. Several commenters recommended allowing coverage of an E0652 PCD for secondary lymphedema of any etiology, with or without ulcers, when diagnostic criteria are met and the E0650 or E0651 has been ineffective at controlling the lymphedema. It was recommended that documentation of trained and supported daily use of a carefully fitted E0650 or E0651 for a minimum of 4 weeks without significant clinical response should be sufficient to evidence the need for the E0652 device. It was recommended the documentation include a detailed description of the therapies recommended in conjunction with the pump as well as provide objective clinical details of why E0650/E0651 device and adjunct therapies were not effective.

   **Response:** The CMS National Coverage Decision (280.6) has determined, "The only time that a segmented, calibrated gradient pneumatic compression device (HCPCs code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a nonsegmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber."

   Review of the clinical literature indicates that the only consistently documented clinical need for an E0652 is for the treatment of lymphedema extending onto the chest, trunk and/or abdomen past the limits of a standard compression sleeve, where the lymphedema has failed to improve with a continued, carefully-performed, good-faith trial of the E0650/E0651 device coupled with other more conservative therapy.

   Commenters indicated a need to use an E0652 where an E0650/E0651 was simply incapable of the task due to conditions of severe obesity, chronicity, fibrosis, number of wounds or other reasons, but there was no literature provided to enable a systematic way to identify these rare situations. The absence of such clinical literature prevents development of criteria to identify individual clinical circumstances and they must therefore continue to be addressed at appeal by individual consideration of a record which must establish that all other more conservative approaches including the continuous, regular use of E0650/E0651 over time have proven insufficient, whereas a trial of the E0652 has been successful.

4. Several commenters raised a concern that the draft LCD conflicts with NCD 280.6 for PCDs by being more restrictive than the NCD in the coverage afforded to causes of lymphedema.

   **Response:** The revised LCD broadens the allowed indications and thereby specifically addresses any concern in this area. There is no conflict with the revised LCD and the NCD.

5. One commenter recommended that an inability to tolerate compression bandaging for venous ulcers should be an immediate indication for venous compression regardless of the length of time the ulcers have been present.

   **Response:** This is not an option for the DME MACs under NCD 280.6.

6. One commenter recommended that the six-month period of conservative therapy for venous stasis ulcers be reduced to four months. Other commenters also objected to the six-month requirement.

   **Response:** This is not an option for the DME MACs under NCD 280.6.

7. Several commenters recommended that PCDs should be covered for chronic venous insufficiency even in the absence of ulcers.

   **Response:** This is not an option for the DME MACs under NCD 280.6. However, the coverage of lymphedema from various causes has been broadened which will likely accomplish much of what these commenters desire.

8. One commenter felt the language *"…has failed to improve with a period of at least four weeks of regular daily home use of the E0650 or E0651 with careful, in-person fitting, overview and training by a technician skilled in and regularly, successfully using the appliances prescribed.."* is unclear.

   **Response:** The language and formatting have been clarified.

9. One commenter recommended that an E0652 be allowed for unilateral limb edema, documented to be unresponsive to use of E0651/E0650 coupled with other more conservative measures, on a prior authorization basis.

   **Response:** This recommendation is beyond the scope of the current LCD and Policy Article revisions.

10. One large manufacturer of PCDs recommended that part of the current focus in the NCD and LCD about usage of the E0650 and E0651 was because of price differential and that with improvements in technology and cost-efficiencies in recent years, Medicare should reduce the reimbursement for E0652 and relax requirements for use of this code.

    **Response:** This recommendation is beyond the scope of the current LCD and Policy Article revisions.

11. Quite a number of commenters had recommendations and/or concerns about the rapidity and duration of inflation and deflation times for arterial compression devices, indicating these are critical variables in their functional efficacy and that a number of the products on the market seeking coverage do not have comparable functional efficacy. Others had concerns that the manufacturing requirements for arterial compression devices were not adequately addressed, including a number of very detailed and well-documented observations, reports of research on various parameters and peer-reviewed articles on these topics

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

12. Multiple commenters objected to the requirement that the ordering of an E0675 was being restricted to a vascular surgeon.

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

13. Several commenters pointed out that angiographic dye may be contraindicated in some patients and therefore alternative diagnostic methods for severity of arterial disease are necessary.

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

14. Several commenters offered recommendations and/or concerns about the recertification of the need for PCDs for arterial compression.

    **Response:** Coverage of arterial compression devices (E0675) is not being added at this time.

15. Several commenters indicated podiatrists should be an eligible provider type to order PCDs, rather than have ordering providers limited to physicians (MD, DO) and physician extenders (NP, PA & CNS). Specifically, in response to the proposed fall 2014 revision released in September 2014, intended to be effective 11/01/2014, it was pointed out by multiple stakeholders and societies, including representatives of the American Podiatric Medical Association, that the language of the LCD was more restrictive than many state scope of practice requirements.

    **Response:** We agree. This was one of several important reasons for withdrawal of the proposed fall 2014 revision. The language has been changed to be specifically consistent with state scope of practice requirements.

16. One commenter indicated PCDs are very effective in his vascular surgery practice without needing to use or try more conservative measures first and on that basis they should be a first-line therapy for this condition.

    **Response:** The Medical Directors disagree. Many therapies and testing modalities may be effective for conditions which would otherwise respond to simpler, conservative measures. The logic of medical necessity indicates that such interventions should be used in series, first using simpler measures shown by accepted clinical practice to often be effective, unless there is a clear evidence basis to skip these simpler measures for the specific clinical circumstances.

17. One commenter pointed out the word "endoscopic" should be changed on page four.

    **Response:** We agree. The language has been changed.

18. Two commenters pointed out that the CMN for pneumatic compression pumps, CMS Form 846 (DME Form 04.04B), does not track with the NCD and LCD requirements which causes confusion in submitting claims.

    **Response:** We agree, but this is currently beyond the scope of this LCD and Policy Article revision.

19. Several commenters pointed out that the proposed fall 2014 revision required a patient to present with "chronic and severe" lymphedema of 6 months duration before any potential qualification for PCD and that this is more restrictive than the NCD or draft LCD, which both require failure of 4 weeks conservative therapy and did not stratify by severity. Further the LCD did not define "severe" lymphedema nor did it refer to accepted lymphedema staging stratification.

    **Response:** The Medical Directors agree and acknowledge this was an error, one of the reasons for our withdrawal of the proposed fall 2014 revision, and we thank the several sources who brought this to our attention. This has been corrected and clarified in the current future LCD.

20. Commenters pointed out that the proposed fall 2014 revision required that conservative therapy "must include the component of Manual Lymphatic Drainage (MLD) which is more restrictive than the NCD."

    **Response:** The language has been changed to reinforce the current clear standard of care that MLD should be used and taught for self-application when available but otherwise is not a requirement.

21. One comment objected that the proposed fall 2014 revision indicates "PCDs are not covered if there is any improvement after use of conservative therapy." The concern is that "delaying implementation of therapeutic interventions in this manner does not represent sound clinical practice. Minimal improvement may not be clinically meaningful. Clinical interventions are made when the clinician determines that the patient, while perhaps exhibiting some incremental improvement, is not achieving the level of therapeutic goals that is appropriate in a given timeframe."

    **Response:** If there is improvement, it follows that the improvement may continue with current therapy. The logical end-point of conservative therapy may only be determined by serial re-examinations. If improvement fails to continue as documented by these serial re-examinations, then a PCD may be covered.

22. One comment objected that the proposed fall 2014 revision inappropriately "requires medications as part of conservative therapy."

    **Response:** The language has been changed to indicate medications should be used as clinically indicated.

## RADS

### Respiratory Assist Devices (HCPCS E0470) Final Edit Effectiveness Results of Service Specific Prepayment Review

The final edit effectiveness results from the Jurisdiction D Medical Review Department from June 2015 through September 2015 are as follows:

The E0470 review currently has an overall potential improper payment rate of 66%.

**The top reasons for denial were:**

- Documentation submitted does not support the coverage criteria.
- Documentation was invalid or did not support a new initial face to face for a beneficiary who switched to an E0470 after greater than three months use of the E0601.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.

For complete details, see Respiratory Assist Devices (HCPCS E0470) Final Edit Effectiveness Results of Service Specific Prepayment Review.

# ASP Medicare Part B Drug Pricing Files – January 2016 – Revised

MLN Matters® Number: MM9351 Revised
Related Change Request (CR) #: CR 9351
Related CR Release Date: September 18, 2015
Effective Date: January 1, 2016
Related CR Transmittal #: R3354CP
Implementation Date: January 4, 2016

**This article was revised on September 23, 2015, to correct the title of the article. All other information remains the same.**

## Provider Types Affected

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

## Provider Action Needed

Medicare will use the January 2016 quarterly Average Sales Price (ASP) Medicare Part B drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 1, 2016, with dates of services from January 1, 2016, through March 31, 2016.

Chage Request (CR) 9351, from which this article is taken, instructs MACs to implement the January 2016 ASP Medicare Part B drug pricing file for Medicare Part B drugs, and if they are released by the Centers for Medicare & Medicaid Services (CMS), to also implement the revised October 2015, July 2015, and April 2015, and January 2015 files. Make sure your billing personnel are aware of these changes.

## Background

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply MACs with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Medicare Claims Processing Manual, Chapter 4, Section 50, Outpatient Code Editor (OCE).

The following table shows how the files will be applied.

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

## Additional Information

The official instruction, CR 9351, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3354CP.pdf on the CMS website.

# DMEPOS Fee Schedule – 2016 Update

**MLN Matters® Number: MM9431**
**Related Change Request (CR) #: CR 9431**
**Related CR Release Date: November 23, 2015**
**Effective Date: January 1, 2016**
**Related CR Transmittal #: R3416CP**
**Implementation Date: January 4, 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) 9431 provides the CY 2016 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

## Background

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

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 the National Competitive Bidding Program (CBP). The Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP.

CMS issued a final rule on November 6, 2014 (79 FR 66223) on the methodologies for adjusting DMEPOS fee schedule amounts using information from competitive bidding programs. Program instructions on these changes are also available in Transmittal 3350, CR 9239 on September 11, 2015. 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.

**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 or RSPAs are also subject to a national ceiling (110% of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (i.e., those included in more than 10 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 §414.202 define a rural areas to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any metropolitan statistical area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA.

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

   Areas outside the contiguous United States (i.e., noncontiguous 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 Areas**

   DME items included in 10 or fewer CBAs receive adjusted fee schedule amounts so that they are equal to 110 percent of the straight average of the SPAs for the 10 or fewer CBAs. This methodology applies to all areas (i.e., non-contiguous and contiguous).

## Phasing In Fee Schedule Amounts

The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that 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.

For claims with dates of service on or after July 1, 2016, the July quarterly update files will include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts.

Fee schedule amounts that are adjusted using SPAs will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where the SPAs from CBPs no longer in effect are used to adjust fee schedule amounts (§414.210(g)(4)), 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 or 2018) claims with dates of service on or after July 1, 2016, the fee schedule amount on the DMEPOS file is based on 100 percent of the adjusted fee schedule amount.

## Fee Schedule and Rural ZIP Code Files

The DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodologies discussed above as well as codes that are not subject to the fee schedule CBP adjustments taking effect January 1, 2016. In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file has been updated to include rural payment amounts for those 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 will transition to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology will remain unchanged. The DMEPOS and PEN fee schedules and the Rural ZIP code file Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties after October 29, 2015 at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched on the CMS website.

## New Codes Added Effective January 1, 2016:

The HCPCS codes A4337, E1012, E0465, E0466, and L8607. are being added to the HCPCS effective January 1, 2016. Codes E1012, E0465, E0466, and L8607 will be added to the DMEPOS fee schedule file effective January 1, 2016.

## Codes Deleted

The following codes will be deleted from the DMEPOS fee schedule files effective January 1, 2016: E0450, E0460, E0461, E0463, and E0464.

## Shoe Modification Codes

Effective January 1, 2016, CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2016. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2016, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during CY 2014.

## Update to CR8566 – Wheelchair Accessory

Also as part of CR9431, CMS is adding HCPCS code E1012 (wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type). Code E1012 is eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair, effective January 1, 2016.

## The 2015 Deflation Factors for Gap-Filling Purposes

For gap-filling pricing purposes, the 2015 deflation factors by payment category are: 0.459 for Oxygen, 0.462 for Capped Rental, 0.463 for Prosthetics and Orthotics, 0.588 for Surgical Dressings, 0.639 for Parental and Enteral Nutrition, 0.978 for Splints and Casts and 0.962 for Intraocular Lenses.

## Ventilators

Fee schedules are being added for the following ventilator HCPCS codes:

- E0465 Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube); and
- Code E0466 Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell).

Code E0465 is added to the HCPCS for billing Medicare claims previously submitted under E0450 and E0463. Code E0466 is added to the HCPCS for billing Medicare claims previously submitted under E0460, E0461 and E0464. The fee schedule amounts for codes E0465 and E0466 are established using the Medicare fee schedule amounts for HCPCS code E0450, based on updated average reasonable charges for ventilators from July 1, 1986, through June 30, 1987.

## 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, A4259 are not updated by the covered item update. In accordance with the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order CBP under the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated. The CBP for mail order diabetic supplies is effective July 1, 2013 to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, CR 8325, dated May 17, 2013, and Transmittal 2661, CR 8204, dated February 22, 2013. (See related MLN Matters Articles MM8325 and MM8204)

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data only for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts will be updated annually by the covered item update factor adjusted for multi-factor productivity. The mail order DTS fee schedule amounts are not used in determining the Medicare allowed payment amounts for mail order DTS. The single payment amount Public Use File (PUF) for the national mail order CBP is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with The Act, the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the single payment amounts established under the national mail order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the six-month phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which are based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order single payment amounts, will be provided on the DMEPOS fee schedule file in the Hawaii column of the mail order (KL) DTS (A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259) codes 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. The Northern Mariana Island DTS mail order payment amounts will no longer appear in the Hawaii column and the DTS mail order (KL) fee schedules for all states and territories will be removed from the DMEPOS fee schedule file as of July 1, 2016.

## 2016 Fee Schedule Update Factor of -0.4 Percent

For CY 2016, an update factor of 0.1 percent is applied to certain DMEPOS fee schedule amounts. For the majority of fee schedule amounts, in accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2016 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2015, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi[AG5] -Factor Productivity (MFP). The MFP adjustment is 0.5 percent and the CPI-U percentage increase is 0.1 percent. Thus, the 0.1 percentage increase in the CPI-U is reduced by the 0.5 percentage increase in the MFP resulting in a net decrease of -0.4 percent for the update factor.

## 2016 Update Labor Payment Rates for HCPCS Codes K0739, L4205 and L7520 January 1, 2016 through December 31, 2016

The 2016 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2016, through December 31, 2016. Those amounts are as follows:

| STATE | K0739 | L4205 | L7520 |
|---|---|---|---|
| **AK** | $28.01 | $31.91 | $37.54 |
| **AL** | $14.87 | $22.16 | $30.08 |
| **AR** | $14.87 | $22.16 | $30.08 |
| **AZ** | $18.39 | $22.13 | $37.01 |
| **CA** | $22.81 | $36.38 | $42.39 |
| **CO** | $14.87 | $22.16 | $30.08 |
| **CT** | $24.83 | $22.65 | $30.08 |
| **DC** | $14.87 | $22.13 | $30.08 |
| **DE** | $27.38 | $22.13 | $30.08 |
| **FL** | $14.87 | $22.16 | $30.08 |
| **GA** | $14.87 | $22.16 | $30.08 |
| **HI** | $18.39 | $31.91 | $37.54 |
| **IA** | $14.87 | $22.13 | $36.01 |
| **ID** | $14.87 | $22.13 | $30.08 |
| **IL** | $14.87 | $22.13 | $30.08 |
| **IN** | $14.87 | $22.13 | $30.08 |
| **KS** | $14.87 | $22.13 | $37.54 |
| **KY** | $14.87 | $28.37 | $38.47 |

| STATE | K0739 | L4205 | L7520 |
|---|---|---|---|
| LA | $14.87 | $22.16 | $30.08 |
| MA | $24.83 | $22.13 | $30.08 |
| MD | $14.87 | $22.13 | $30.08 |
| ME | $24.83 | $22.13 | $30.08 |
| MI | $14.87 | $22.13 | $30.08 |
| MN | $14.87 | $22.13 | $30.08 |
| MO | $14.87 | $22.13 | $30.08 |
| MS | $14.87 | $22.16 | $30.08 |
| MT | $14.87 | $22.13 | $37.54 |
| NC | $14.87 | $22.16 | $30.08 |
| ND | $18.53 | $31.84 | $37.54 |
| NE | $14.87 | $22.13 | $41.94 |
| NH | $15.97 | $22.13 | $30.08 |
| NJ | $20.06 | $22.13 | $30.08 |
| NM | $14.87 | $22.16 | $30.08 |
| NV | $23.69 | $22.13 | $41.00 |
| NY | $27.38 | $22.16 | $30.08 |
| OH | $14.87 | $22.13 | $30.08 |
| OK | $14.87 | $22.16 | $30.08 |
| OR | $14.87 | $22.13 | $43.25 |
| PA | $15.97 | $22.79 | $30.08 |
| PR | $14.87 | $22.16 | $30.08 |
| RI | $17.72 | $22.81 | $30.08 |
| SC | $14.87 | $22.16 | $30.08 |
| SD | $16.62 | $22.13 | $40.22 |
| TN | $14.87 | $22.16 | $30.08 |
| TX | $14.87 | $22.16 | $30.08 |
| UT | $14.91 | $22.13 | $46.84 |
| VA | $14.87 | $22.13 | $30.08 |
| VI | $14.87 | $22.16 | $30.08 |
| VT | $15.97 | $22.13 | $30.08 |
| WA | $23.69 | $32.47 | $38.57 |
| WI | $14.87 | $22.13 | $30.08 |
| WV | $14.87 | $22.13 | $30.08 |
| WY | $20.73 | $29.53 | $41.94 |

## 2016 National Monthly Fee Schedule Amounts for Stationary Oxygen Equipment

CMS is implementing the 2016 national monthly fee schedule payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2016, through June 2016. The updated national 2016 monthly payment amount of $180.10 for the stationary oxygen equipment codes will not appear on the 2016 DMEPOS fee schedule. Instead, for dates of service January 1, 2016, through June 30, 2016, the 2016 fee schedule rate of $180.10 blends with the stationary oxygen regional SPAs based on 50 percent of the un-adjusted stationary oxygen fee schedule amounts and 50 percent of the adjusted oxygen regional SPAs.

Beginning July 1, 2016, the stationary oxygen equipment fee schedule amounts on the quarterly update to the CY 2016 DMEPOS fee schedule file will reflect 100 percent of the adjusted oxygen regional SPAs.

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

## 2016 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2016 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, Change Request (CR) 6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. (See related MLN Matters Articles MM6792 and MM6990) To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433, or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR §414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2016 maintenance and servicing fee is adjusted by the -0.4 percent MFP-adjusted covered item update factor to yield a CY 2016 maintenance and servicing fee of $69.48 for oxygen concentrators and transfilling equipment.

## Additional Information

The official instruction, CR9431, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3416CP.pdf on the CMS website.

# RARC, CARC, MREP and PC Print Update – Revised

MLN Matters® Number: MM9278 Revised
Related CR Release Date: August 6, 2015
Related Transmittal #: R3298CP
Change Request (CR) #: CR 9278
Effective Date: October 1, 2015
Implementation Date: October 5, 2015

**This article was revised on October 13, 2015, to correct a code in the Modified Codes – RARC table on pages 3-4. The code of N109 is now shown in that table, instead of the incorrect code of M109. All other information remains the same.**

## Provider Types Affected

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

## Provider Action Needed

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

Change Request (CR) 9278 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software used by some providers. Make sure that your billing staffs are aware of these updates.

## 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 Claim Adjustment Reason Codes (CARCs) and appropriate Remittance Advice Remark Codes (RARCs) 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 CARC and RARC changes that impact Medicare are usually requested by staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. If any new or modified code has an effective date past the implementation date specified in CR9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release schedule. CR9278 lists only the changes that have been approved since the last code update by CR9125 issued on April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at http://www.wpc-edi.com/Reference on the WPC website.

## Changes in RARC List Since CR9125

**New Codes – RARC**

| Code | Modified Narrative | Effective Date |
|---|---|---|
| **N753** | Missing/Incomplete/Invalid Attachment Control Number. | 07/01/2015 |
| **N754** | Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form. | 07/01/2015 |
| **N755** | Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form. | 07/01/2015 |
| **N756** | Missing/Incomplete/Invalid point of drop-off address, | 07/01/2015 |
| **N757** | Adjusted based on the Federal Indian Fees schedule (MLR). | 07/01/2015 |
| **N758** | Adjusted based on the prior authorization decision. | 07/01/2015 |
| **N759** | Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013. | 07/01/2015 |

**Modified Codes – RARC**

| Code | Modified Narrative | Effective Date |
|---|---|---|
| **M47** | Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN). | 07/01/2015 |
| **MA74** | ALERT: This payment replaces an earlier payment for this claim that was either lost, damaged or returned. | 07/01/2015 |
| **N432** | ALERT: Adjustment based on a Recovery Audit. | 07/01/2015 |
| **N22** | ALERT: This procedure code was added/changed because it more accurately describes the services rendered. | 07/01/2015 |
| **M39** | ALERT: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements. | 07/01/2015 |
| **N109** | ALERT: This claim/service was chosen for complex review. | 07/01/2015 |
| **M38** | ALERT: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges. | 07/01/2015 |
| **N381** | ALERT: Consult our contractual agreement for restrictions/billing/payment information related to these charges. | 07/01/2015 |
| **MA91** | ALERT: This determination is the result of the appeal you filed. | 07/01/2015 |

**Deactivated Codes – RARC**

| Code | Current Narrative | Effective Date |
|---|---|---|
| **N102** | This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely. | 07/01/2016 |

***N735** - This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.

### Changes in CARC List Since CR9125

**New Code – CARC**

| Code | Modified Narrative | Effective Date |
|---|---|---|
| **270** | Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration. | 07/01/2015 |

Modified Code – CARC

| Code | Modified Narrative | Effective Date |
|---|---|---|
| **45** | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.<br>**Note:** This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability.) | 11/01/2015 |

There have been no deactivated CARC codes since CR9125.

In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

### Additional Information

The official instruction, CR9278, issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.pdf on the CMS website.

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

**MLN Matters® Number: MM9350**
**Related Change Request (CR) #: CR 9350**
**Related CR Release Date: November 20, 2015**
**Effective Date: April 1, 2016**
**Related CR Transmittal #: R3411CP**
**Implementation Date: April 4, 2016**

### Provider Types Affected

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

### Provider Action Needed

Change Request (CR) 9350 instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule publication. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2016.

### Background

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set that must be implemented by January 1, 2014, under the Patient Protection and Affordable Care Act of 2010.

The Health Insurance Portability and Accountability Act (HIPAA) amended the Social Security Act (the Act) by adding Part C—Administrative Simplification—to Title XI, requiring that the Secretary of HHS (the Secretary) 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.

CR9350 deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE will publish the next version of the Code Combination List on or about February 1, 2016. This update is based on the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) updates as posted at the Washington Publishing Company (WPC) website on or about November 1, 2015.

Visit 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.

### Additional Information

The official instruction, CR9350, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3411CP.pdf on the CMS website.

## MREP Upgrade

**MLN Matters® Number: MM9291**
**Related CR Release Date: November 5, 2015**
**Related Transmittal #: R1552OTN**
**Change Request (CR) #: CR 9291**
**Implementation Date: April 4, 2016**
**Effective Date: April 1, 2016**

### Provider Types Affected

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

### What You Need to Know

Change Request (CR) 9291 contains upgrades to Medicare Remit Easy Print (MREP) software based on enhancement requests received through the Medicare Administrative Contractors (MACs) and/or the Centers for Medicare & Medicaid Services (CMS) website.

This software is available free of charge from the CMS website and now offers a number of special reports that users can view and download in addition to the remittance advice. Make sure that your billing staffs are aware of these changes.

### Background

MREP software was developed by CMS to help providers to transition to Electronic Remittance Advice (ERA) by offering to translate the ERA into a humanly readable format. CMS introduced the software in October 2005, and has continuously enhanced the software based on feedback from the end users.

CMS offers free software - MREP - to view and print Health Insurance Portability and Accountability Act (HIPAA) compliant ERA, transaction 835 - Health Care Claim Payment/Advice. The software gets enhanced on a regular basis to meet the changing needs of providers/suppliers to help them transition to ERA.

## REMITTANCE ADVICE

A key change in this version of the MREP application is an upgrade so that when a user prints the Claim Detail with the Glossary option selected, the Glossary will begin on the same page of the last claim if there are available print lines on the page, rather than always printing on a new page.

Another upgrade to the MREP application is that the Claim Adjustment Reason Code (CARC) is added as a new criteria option for the existing search functionality. The search scope will be limited to a single selected remit, as it is today.

### Additional Information

The official instruction, CR9291, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1552OTN.pdf on the CMS website.

## SPEECH GENERATING DEVICES

# Speech Generating Devices – Coding Verification Review Requirement

### Joint DME MAC & PDAC Publication

The Pricing, Data Analysis, and Coding (PDAC) contractor is conducting Coding Verification Reviews for code E2510 (SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS).
All products currently listed on the Pricing, Data Analysis, and Coding (PDAC) contractor website with HCPCS code E2510 will be end dated effective May 31, 2016. Manufacturers will be required to submit a new coding verification application to the PDAC for review and assignment of the correct code for products currently coded as E2510.

Effective for claims with dates of service on or after June 1, 2016, the only products which may be billed to Medicare using code E2510 are those for which a written coding verification has been made by the PDAC contractor and are listed on the Product Classification List in the Durable Medical Equipment Coding System (DMECS) maintained on the PDAC website, https://www.dmepdac.com/dmecsapp/do/search.

The PDAC coding verification application required for these products is the DME and Supplies application. This application is located on the PDAC website, https://www.dmepdac.com/review/apps_check.html.

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

The Speech Generating Devices Local Coverage Determination and related Policy Article will be updated with this information at a later date.

# SURGICAL DRESSINGS

## DME on Demand – Surgical Dressings: Medical Records

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

**This session will include:**

- Medical Records
- Assessment: Required Elements
- Resources

### Viewing Presentation

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

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

# UROLOGICAL SUPPLIES

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

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

The A4351 review currently has an overall potential improper payment rate of 60%, the A4353 review currently has an overall potential improper payment rate of 80%, and the A4358 review currently has an overall potential improper payment rate of 82%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- The order was incomplete or missing elements.
- No office notes or medical records were received.
- The refill request was incomplete or was missing elements.
- The documentation submitted does not support that the bene requires catheterization and meets at least one of the qualifying criteria.

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

## Urological Supplies (HCPCS A4357) Quarterly Results of Service Specific Prepayment Review

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

The A4357 review currently has an overall potential improper payment rate of 84%.

**The top reasons for denial were:**

- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- No office notes or medical records were provided.
- The Detailed Written Order (DWO) is incomplete or missing elements.
- The refill request is incomplete or missing elements.

For complete details see, Urological Supplies (HCPCS A4357) Quarterly Results of Service Specific Prepayment Review.

## Vacuum Erection Devices (HCPCS L7900) Quarterly Results of Service Specific Prepayment Review

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from May 2015 through August 2015 are as follows:

The L7900 review currently has an overall potential improper payment rate of 93%.

**The top reasons for denial were:**

- Docuentation submitted does not meet coverage criteria.
- A diagnosis code that justifies the need for the item billed was not included.
- No documentation was received in response to the Additional Documentation Request (ADR) letter.
- Documentation submitted does not support the ordering physician is treating the beneficiary for a disease or condition to justify the code billed.

For complete details, see Vacuum Erection Devices (HCPCS L7900) Quarterly Results of Service Specific Prepayment Review.

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