DME Happenings

Jurisdiction D
Issue No. 46
March 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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Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

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CERT

CODING

COMPETITIVE BIDDING

DOCUMENTATION

DRUGS AND BIOLOGICALS

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Alphabetical Listing

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for Eligibility and general information 6 am – 8 pm CT Menu options requiring system access: Same and Similar HCPCS Lookup, Claim Status, Payment Floor, Checks, Duplicate Remittance Advice, Overpayments, Provider Enrollment, Appeals Status and CMN Status
Supplier Contact Center	1-877-320-0390	8 am – 6 pm CT Monday-Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-877-320-0390	8 am – 4:30 pm CT
Website: www.noridianmedicare.com/dme		
Fax		
Reopenings and Redeterminations MSP Inquiries and Refunds DME Recovery Auditor Redeterminations		1-701-277-7886
Refunds to Medicare Immediate Offsets		1-701-277-7894
DME Recovery Auditor Offsets		1-701-277-7896
Medical Review Medical Documentation		1-701-277-7888
CERT Medical Documentation		1-701-277-7890
Noridian Email Addresses		
Noridian DME Customer Service		dme@noridian.com
Reopenings and Redeterminations		dmeredeterminations@noridian.com
Noridian DME Endeavor		dmeendeavor@noridian.com
Mailing Addresses		
Claims, Redetermination Requests, Correspondence, ADMC Requests and Medical Review Documentation Noridian PO Box 6727 Fargo ND 58108-6727		**Benefit Protection** Noridian Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736
Administrative Simplification Compliance Act Exception Requests Noridian PO Box 6737 Fargo ND 58108-6737		**Qualified Independent Contractor** C2C Solutions, Inc. Attn: DME QIC PO Box 44013 Jacksonville FL 32231-4013
Electronic Funds Transfer Forms/Overpayment Redeterminations/DME Recovery Auditor Redeterminations Noridian PO Box 6728 Fargo ND 58108-6728		**DME Recovery Auditor Overpayments** Noridian PO Box 6759 Fargo ND 58108-6759

CONTACT US

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

FYI

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 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 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 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
Off-the-Phone Training	August 21, 2015	9:40 a.m. – 12 p.m. CT

Event	Date	Closure Timeframe
Off-the-Phone Training	August 28, 2015	9:40 a.m. – 12 p.m. CT
Labor Day	September 7, 2015	Entire Day Closed 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 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 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
8 a.m. – 6 p.m. CT	June 7	8 – 10 a.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
8 a.m. – 6 p.m. CT	December 24	12 – 4 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 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 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 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 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.

MLN Connects Provider eNews – December 4, 2014

MLN Connects™ Provider eNews for December 4, 2014

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes – Last Chance to Register
- Certifying Patients for the Medicare Home Health Benefit – Register Now

MLN Connects™ Videos

- Monthly Spotlight: Physician Feedback Program/Value-based Payment Modifier

CMS Events

- Webinar for Comparative Billing Report on Modifier 25: Family Practice

Announcements

- National Influenza Vaccination Week – December 7-13
- CMS Releases New Proposal to Improve Accountable Care Organizations
- Efforts to Improve Patient Safety Result in 1.3 Million Fewer Patient Harms, 50,000 Lives Saved and $12 Billion in Health Spending Avoided
- Provider Enrollment Application Fee Amount for CY 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- ICD-10 MS-DRGs v32 Software Now Available
- Inpatient PPS FY 2014.8 PC Pricer Updated
- Clarification of Specialty Care Transport Payment Policy for Ambulance Transportation Services

Medicare Learning Network® Educational Products

- "Affordable Care Act Provider Compliance Programs: Getting Started" Web-Based Training Course – Released
- "Complying With Medical Record Documentation Requirements" Fact Sheet – Released
- "Hospital Reclassifications" Fact Sheet – Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects™ Provider eNews for December 11, 2014

MLN Connects™ Provider eNews for December 11, 2014

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In This Edition:

MLN Connects™ National Provider Calls

- Certifying Patients for the Medicare Home Health Benefit - Last Chance to Register
- ESRD QIP Payment Years 2017 and 2018 Final Rule - Registration Opening Soon

MLN Connects™ Videos

- Coding for ICD-10-CM: More of the Basics

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April - Registration Opening Soon
- QRDA I and III Submissions for Eligible Professionals eHealth Provider Webinar
- Physician Compare Virtual Office Hour Session

Announcements

- New CMS Rules Enhance Medicare Provider Oversight; Strengthens Beneficiary Protections
- New Requirements for Prescribers of Medicare Part D Drugs
- ESRD PPS Low-Volume Payment Adjustment: Act by December 31
- Eligible Hospitals Must Attest By December 31 to Receive 2014 EHR Incentive
- Financial Incentives and Ability to Exchange Clinical Information Found to be Top Reasons for EHR Adoption
- HHS Awards $36.3 Million in Affordable Care Act Funding to Reward and Expand Quality Improvement in Health Centers
- See the Big Picture with Open Payments Search Tool Enhancements
- Contractor Assists Hospitals in Reporting Inpatient Quality Data
- Updates to IRIS Software
- Access Your 2013 QRUR
- 2012 Supplemental QRURs Available to Group Practices
- EHR Incentive Programs: Protect Electronic Health Information Core Objective
- Get Ready Now for ICD-10

Claims, Pricers, and Codes

- January 2015 Average Sales Price Files Now Available
- Medicare Learning Network® Educational Products
- "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach" MLN Matters® Article – Revised
- "Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs" MLN Matters® Article – Revised
- "Skilled Nursing Facility Billing Reference" Fact Sheet - Revised
- The Basics of Internet-based PECOS for DMEPOS Suppliers" Fact Sheet - Reminder
- New Medicare Learning Network® Provider Compliance Fast Fact

Medicare Learning Network® Products Available In Electronic Publication Format

- Submit Your Feedback on the Medicare Learning Network® Learning Management System and Product Ordering System

MLN Connects Provider eNews – December 18, 2014

MLN Connects™ Provider eNews for December 18, 2014

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In This Edition:

MLN Connects™ National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process – Registration Opening Soon
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 – Registration Now Open
- ESRD QIP Payment Year 2017 and 2018 Final Rule – Registration Now Open
- New MLN Connects™ National Provider Call Video Slideshow, Audio Recording, and Transcript

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Forms Due January 9

Announcements

- CDC Continues to Recommend a Flu Vaccine as the Best Way to Protect Against the Flu
- Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage Overview
- HIS Data Collection for FY 2016 Annual Payment Update Ends December 31
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- Frequently Asked Questions on DMEPOS 2015 Medicare Payment Final Rule
- Open Payments: Final Rule Changes Related to Continuing Education Events
- Comparative Billing Report on Modifier 59: Dermatology

Claims, Pricers, and Codes

- Reprocessing of IPPS Claims Assigned to DRG 410, 573 or 907
- Medicare Learning Network® Educational Products
- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article – Released

"Medical Privacy of Protected Health Information" Fact Sheet – Revised

- Medicare Learning Network Products® Available In Electronic Publication Format

MLN Connects™ Provider eNews for January 8, 2015

MLN Connects™ Provider eNews for January 8, 2015

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In This Edition:

MLN Connects™ National Provider Calls

- Medicare Quality Reporting Programs: Data Submission Process – Last Chance to Register
- IRF PPS: New IRF-PAI Items Effective October 1, 2015 – Last Chance to Register
- ESRD QIP Payment Year 2017 and 2018 Final Rule – Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

- Continuing Education for Participation in MLN Connects™ National Provider Calls

MLN Connects™ Videos

- Monthly Spotlight: The 2-Midnight Benchmark Rule

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Deadline Extended to January 21
- Open Payments Question & Answer Session
- Physician Compare Virtual Office Hour Session
- ICD-10 Clinical Documentation Improvement Webinar Recording Available

Announcements

- Get Your Patients Off to a Healthy Start in 2015 with the AWV and the IPPE
- Public Reporting of 2013 Quality Measures on the Physician Compare and Hospital Compare Websites
- FY 2015 Results for the HAC Reduction Program and Hospital VBP Program
- ACOs Moving Ahead: New Participants in Medicare Shared Savings Program
- CMS Updates Open Payments Data
- Open Payments System Unavailable in January
- January Quarterly Provider Update Available
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act
- IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services
- Hospice Claims Returned in Error for Edit U5181
- Part A Claims Hold for Select Preventive and Screening Services

Medicare Learning Network® Educational Products

- "Certifying Patients for the Medicare Home Health Benefit" MLN Matters® Article – Released
- "Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations" MLN Matters® Article – Released
- "The 2013 Physician Quality Reporting System (PQRS)" Booklet – Released
- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article – Revised
- "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet – Revised
- "Discharge Planning" Booklet – Revised
- "The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet – Reminder
- "The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" Fact Sheet – Reminder

Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects Provider eNews – January 15, 2015

MLN Connects™ Provider eNews for Thursday, January 15, 2015

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In This Edition:

Editor's Note

Thank you for providing feedback about the MLN Connects™ Provider eNews in 2014. We take your feedback seriously and have used it to enhance the eNews throughout the year. It is easier than ever to give us feedback on your eNews experience in 2015. Please continue to let us know how the eNews is helping you or provide us any suggestions you may have. Have a great year.

MLN Connects™ National Provider Calls

- ESRD QIP Payment Year 2017 and 2018 Final Rule – Last Chance to Register

CMS Events

- Volunteer for ICD-10 End-to-End Testing in April – Forms Due January 21
- Webinar for Comparative Billing Report on Modifier 59: Dermatology
- Open Payments Program Overview Video Tutorial Now Available

Announcements

- Help Protect the Vision of Your Medicare Patients – Recommend Annual Glaucoma Screening
- Hospice Providers: Continue to Collect and Submit HIS Data in 2015
- Open Payments System Unavailable through Late January

Claims, Pricers, and Codes

- Adjustment of Some Home Health Claims: Update

Medicare Learning Network® Educational Products

- "FAQs – International Classification of Diseases, 10th Edition (ICD-10) Acknowledgement Testing and End-to-End Testing" MLN Matters® Article – Released
- "Ambulance Fee Schedule" Fact Sheet – Revised
- "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet – Revised
- "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course – Revised

MLN Connects Provider eNews – January 22, 2015

MLN Connects™ Provider eNews for January 22, 2015

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In This Edition:

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Upcoming 2015 Calls

CMS Events

- eHealth Webinar: QRDA I Submission for Eligible Hospitals

Announcements

- Bidding Open for the Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program

- Cervical Health Awareness Month
- Major Improvements to the Internet-based PECOS System
- Submission Timeframes for 2014 PQRS Data
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- Updated Information on Reporting Menu Objectives for the EHR Incentive Programs
- January ICD-10 End-to-End Testing Participants Are Pre-Registered For April Testing
- Share Your ICD-10 Story

Claims, Pricers, and Codes

- January 2015 PPS Provider Data Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2015 Inpatient PPS 2015.3 Mainframe Pricer Update Available
- January 2015 Outpatient Prospective Payment System Pricer File Update
- Part A Claims Hold for Select Preventive and Screening Services – Updated

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 2]" Educational Tool – Released
- "2015 Medicare Part C and Part D Reporting Requirements and Data Validation" Web-Based Training Course – Released
- "Opting out of Medicare and/or Electing to Order and Certify Items and Services to Medicare Beneficiaries" MLN Matters® Article – Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact

Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects Provider eNews – January 29, 2015

MLN Connects™ Provider eNews for January 29, 2015

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In This Edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services Under CY 2015 Medicare PFS – Registration Now Open
- ICD-10 Implementation and Medicare Testing – Registration Now Open
- New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

- Special Open Door Forum: Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy
- Special Open Door Forum: Understanding Dialysis Facility Compare-Driving Informed Decision Making
- Special Open Door Forum: Adding Star Ratings to the Home Health Compare Website

Announcements

- Influenza Updates from CDC
- Pneumococcal Vaccinations Update from CMS
- CMS Launches Dialysis Facility Compare Star Ratings
- HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value

- EHR Incentive Program: Eligible Professional 2014 Attestation Deadline on February 28
- EHR Incentive Programs: New Stage 2 Summary of Care FAQ Provides Guidance on Measure #3
- Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- ICD-10 Resources

Claims, Pricers, and Codes

- Payment for HCPCS Code Q0091 as an RHC or FQHC Billable Visit under the All-Inclusive Rate System

Medicare Learning Network® Educational Products

- "Continued Use of Modifier 59 after January 1, 2015" MLN Matters® Article – Released
- "Telehealth Services" Fact Sheet – Revised
- "Medicare Part B Immunization Billing" Educational Tool – Revised
- New Medicare Learning Network® Provider Compliance Fast Fact

Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects Provider eNews – February 5, 2015

MLN Connects™ Provider eNews for February 5, 2015

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MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS – Register Now
- ICD-10 Implementation and Medicare Testing - Register Now
- New MLN Connects™ National Provider Call Audio Recordings and Transcripts

MLN Connects™ Videos

- Monthly Spotlight: Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing

CMS Events

- Special Open Door Forum: Home Health Clinical Templates

Announcements

- HHS Proposes Path to Improve Health Technology and Transform Care
- Extension of Temporary Moratoria on Enrollment of New HHAs, HHA Sub-units and Part B Ambulance Suppliers
- CLIA Individualized Quality Control Plan: Education and Transition Period Ends December 31, 2015
- 2015 PQRS Payment Adjustment and Providers who Rendered Services at RHCs/FQHCs
- Open Payments: Second Year of Data Submission Begins
- CMS Intends to Engage in Rulemaking for EHR Incentive Program Changes for 2015
- Get Started with Hospice CAHPS
- Proposed Decision Memo: Screening for the HIV Infection

Claims, Pricers, and Codes

- Home Health Pricer will be Updated on April 1
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Payment Codes on Home Health Claims Will Be Matched Against Patient Assessments" MLN Matters® Article – Released
- "Extension of Provider Enrollment Moratoria for Home Health Agencies and Part B Ambulance Suppliers" MLN Matters® Article – Revised
- "Internet-based PECOS Contact Information" Fact Sheet – Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format
- Subscribe to the MLN Matters® Electronic Mailing List
- Helpful Tips on Medicare Learning Network® Products and Learning Management System – Subscribe Now

MLN Connects Provider eNews – February 12, 2015

MLN Connects™ Provider eNews for February 12, 2015

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In This Edition:

MLN Connects™ National Provider Calls

- Payment of Chronic Care Management Services under CY 2015 Medicare PFS – Last Chance to Register
- ICD-10 Implementation and Medicare Testing - Register Now
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Registration Now Open

CMS Events

- Physician Compare Benchmark Discussion Webinars

Announcements

- DMEPOS Competitive Bidding: Register by Tuesday in Order to Bid
- February is American Heart Month
- IRF Quality Reporting Program: Data Submission Deadline February 15
- LTCH Quality Reporting Program: Data Submission Deadline February 15
- EHR Incentive Program: 2014 Attestation Deadline for Eligible Professionals February 28
- EHR Incentive Programs: Public Health Objectives: Reporting Requirements in Stage 1 and 2
- NCD for Screening for Lung Cancer with Low Dose Computed Tomography
- Background Fingerprints: Check Your Status Online
- Antipsychotic Drug use in Nursing Homes: Trend Update
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- CY 2015 HH PPS PC Pricer and PPS Main Frame Pricer Updates Available

Medicare Learning Network® Educational Products

- "Hospital Outpatient Prospective Payment System" Fact Sheet – Revised
- "DMEPOS Quality Standards" Booklet - Reminder
- "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies" Fact Sheet – Reminder
- "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet – Reminder

MLN Connects Provider eNews – February 19, 2015

MLN Connects™ Provider eNews for February 19, 2015

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In This Edition:

MLN Connects™ National Provider Calls

- ICD-10 Implementation and Medicare Testing – Last Chance to Register
- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Register Now
- Video Slideshow and Follow-up Information Available for IRF-PAI MLN Connects™ National Provider Call

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015
- Webinar for Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons
- Healthy Aging Summit

Announcements

- New Affordable Care Act Initiative to Encourage Better Oncology Care
- Update for Pharmacists Prescribing Part D Drugs
- Measles: Information for Healthcare Professionals
- Hospitals Must Start Medicare EHR Participation in 2015 to Earn Incentives
- PQRS: Program Year 2014 QRDA III Submission Errors with Incorrect Program Name

Medicare Learning Network® Educational Products

- "Independent Diagnostic Testing Facility (IDTF)" Fact Sheet – Released
- "Chronic Care Management Services" Fact Sheet – Released
- "Provider Compliance Tips for Spinal Orthoses" Fact Sheet – Released
- "Provider Compliance Tips for Enteral Nutrition Pumps" Fact Sheet – Released
- "Provider Compliance Tips for Diabetic Test Strips" Fact Sheet – Released
- "Medicare Learning Network® Suite of Products & Resources for Educators and Students" Educational Tool – Reminder
- "Medicare Learning Network® Suite of Products & Resources for Billers and Coders" Educational Tool – Reminder
- "Medicare Learning Network® Suite of Products & Resources for Inpatient Hospitals" Educational Tool – Reminder
- "Medicare Learning Network® Suite of Products & Resources for Compliance Officers" Educational Tool – Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects Provider eNews – February 26, 2015

MLN Connects™ Provider eNews for February 26, 2015

View this edition as a PDF

In This Edition:

MLN Connects™ National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI – Register Now

- Physician Quality Reporting Programs: Reporting Once in 2015 – Registration Now Open

CMS Events

- Participate in ICD-10 Acknowledgement Testing Week: March 2 through 6, 2015

Announcements

- It's Still Flu Season
- CMS Strengthens Five Star Quality Rating System for Nursing Homes
- EHR Incentive Program: Deadline to Register Intent for a Public Health Measure is March 1
- Hospital Engagement Network Solicitation: Responses due March 30
- Medicare Geographic Reclassification under the IPPS Wage Index for FY 2016
- New FAQs on CY 2015 DMEPOS Medicare Payment Final Rule
- CMS to Release Comparative Billing Report in March on Modifier 25: Nurse Practitioners
- Sterilization of Ophthalmologic Surgical Instruments
- Two New ICD-10 Videos

Medicare Learning Network® Educational Products

- "Medicare Basics Commonly Used Acronyms" Educational Tool – Released
- "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492" MLN Matters® Article – Revised
- "The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program – A Better Way for Medicare to Pay for Medical Equipment" Fact Sheet – Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact

Medicare Learning Network® Products Available In Electronic Publication Format

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."

Phone Number Consolidation to Simplify Phone Appeals, Supplier Contact Center and IVR Effective February 28, 2015

Effective February 28, 2015, Noridian Jurisdiction D suppliers must use this toll-free number, 877-320-0390, when contacting the Interactive Voice Response (IVR), Supplier Contact Center (SCC), or Telephone Reopenings. Providing this single toll-free number for all of these inquiry types will unify our customer service areas and simplify supplier contact. Phone calls will be directed by the caller, through our IVR system. What the IVR is unable to assist with will allow calls to be routed to either Telephone Reopenings or the Supplier Contact Center for the appropriate Customer Service Representative to assist suppliers with their questions.

Visit the Noridian Supplier Contact Center webpage to see details on the following:

- SCC and Telephone Reopenings Hours of Availability
- Call Flow of Single Toll Free Number

- Call Authentication
- SCC Assistance Structure
- Written Inquiries

If needed, the Text Telephone (TTY) number is 866-879-2704.

Single Toll Free Phone Number for Customer Service and Telephone Reopenings

Effective March 1, 2015, the DME Customer Service and DME Telephone Reopening lines will be merged into one single toll free telephone line. Suppliers will dial 1-877-320-0390 for both DME Customer Service and DME Telephone Reopenings. This phone number will bring callers to the Interactive Voice Response (IVR), where callers will be asked if they would like to use one of the self-service options. Callers wanting to proceed directly to a Telephone Reopening Representative will respond "no" to the self-service options and reply "Telephone Reopening" when prompted. After selecting Telephone Reopening, the caller will be routed to a Telephone Reopening Representative. Additional information will be published to the website and sent in the listserv prior to this implementation.

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.

Supplier Manual Updates

The following table outlines updates to the DME MAC Jurisdiction D Online Supplier Manual. The content is ordered with the most current changes appearing on top.

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 13	Reopenings	Updated phone number	03/02/15
Appendix	Resources	Updated phone number	03/02/15
Resources	Jurisdiction D DME MAC Contact Information	Updated MSP Inquiries and Refunds fax number	02/13/15
2	Surety Bond	Updated Link	01/21/15
3	Requirement of New Orders	Removed the words DME PSC	01/21/15
3	Requirement of New Orders	Added title and information for Affordable Care Act and New Orders	01/21/15
3	Continued Medical Need	Added a new section and for titled Documenting Repair Claims	01/21/15
3	Pick up slips	Removed the words DME PSC's	01/21/15
9	General Medical Policy Information	Adjusted the outline layout	01/21/15

Chapter	Subheading	Supplier Manual Update	Change Date
9	Durable Medical Equipment	Added a space line for a new paragraph	01/21/15
11	MSP Recovery Contractor	Correction made on acronym	01/21/15
11	MSP Recovery Contractor	CMS Website link was updated	01/21/15
11	Primary Payer Paid Amount	Allowed amount info. removed	01/21/15
11	Primary Payer Paid Amount	Updated Loop ID information	01/21/15
17	Medicare Remittance Advice	Updated a link	01/21/15
17	Medicare Remittance Advice	Added a sentence at the end of he section	01/21/15
17	Medicare Remit Easy Print	Update CMS website link	01/21/15

Upcoming IVR Enhancement – Subject Matter Inquiry

Effective March 1, 2015, the DME Customer Service and DME Telephone Reopening lines will be merging into one single toll free telephone line. In order to better serve the supplier community, Noridian will also be enhancing the Interactive Voice Response (IVR) during the merge. Before reaching a Customer Service Representative, the IVR will be prompting suppliers regarding the subject matter for which they are calling. These subjects will include: Oxygen, Financial Information, Competitive Bid, or All Other Inquiries. Based on the subject matter, the call will then be routed to the available customer service representative who can most quickly answer their questions. Additional information will be published to the website and sent in the listserv prior to this implementation.

Keys for a Successful Redetermination

It is your right to appeal a decision or request to have a reopening completed if you disagree with a decision on a claim. A reopening is used in order to correct those minor clerical errors or omissions that cause a claim to deny. An appeal is requested when there is a disagreement with a decision. The first level of appeals is the Redetermination which is conducted by the DME MAC as an independent review of the initial decision.

In order to be successful and ensure the response you are looking for in a redetermination request, it is important to understand what is needed when submitting your request as well as how to submit the request.

A Redeterminations resource page has been created to help you with all your redetermination needs.

Key #1 – Understanding Coverage Criteria

Understanding the coverage criteria for the item you are billing is vital to the redetermination of a claim. The Coverage Criteria can be found in the Local Coverage Determinations (LCD) as well as the Policy Articles (PA). All LCDs and PAs can be found on our website at www.noridianmedicare.com/dme/coverage/lcd.html.

Key #2 – Documentation

The documentation required for Medicare coverage is found in the LCDs and PAs. The standard documentation language has been added to the LCDs in order to streamline the process of determining what is required for that policy group. In addition, the policies will detail specifics that are also required for the individual items. Ensuring the review of the entire policy will assist in gathering the most appropriate documentation. When submitting the redetermination, be sure to include all documentation to support not only the current date of service but the initial coverage for the equipment and supplies. Medical records are a key piece of documentation. Medical records are created by medical professionals not employed by the supplier. Examples of medical records include but are not limited to physician chart notes, hospital chart notes, lab tests, x-rays, skilled nursing facility chart notes, home health agency notes, etc. The following are not considered medical records but may be used as supplemental documentation if collaborated by medical

records; supplier or physician prepared statements, letters of medical necessity, orders, etc. Refer to the Program Integrity Manual, Chapter 5, Section 5.7.

Please see below for additional hints for policies appealed most frequently.

Key #3 – How to submit a redetermination

There are several avenues available to submit a redetermination. Please submit your redeterminations using one of the following formats:

- Endeavor: https://www.noridianmedicare.com/ dme/claims/endeavor.html
- Fax: 1-701-277-7886
- Mail: Noridian
  Attn: DME Redeterminations
  PO Box 6727
  Fargo ND 58108-6727
- Overpayment Redeterminations Mail:
  Noridian
  Attn: DME Overpayment Redeterminations
  PO Box 6728
  Fargo ND 58108-6728

All policies require the following:

- Orders
  - Preliminary order if delivered prior to receipt of Detailed Written Order (DWO)
  - DWO
  - Written Order Prior to Delivery (WOPD) for those items impacted by the Affordable Care Act (ACA)
- Medical records/chart notes
  - Supporting the initial medical necessity
  - Supporting continued use (within past 12 months)
  - Supporting continued need (within past 12 months)
- Proof of delivery
  - For all equipment not just appealed date(s) of service
- Advance Beneficiary Notice of Noncoverage (ABN) if properly executed for items that do not meet the reasonable and necessary coverage criteria
- Refill Documentation
  - Consumable supplies: Assess the quantity remaining for each item
  - Nonconsumable supplies: Assess functional status

Policy Specific Documentation needed for each appeal

Not all inclusive list. The following is commonly missing documentation

Oxygen and Oxygen Equipment

- Certificate of Medical Necessity (CMN)
  - Initial CMN
  - Revised CMNs
  - Recert CMNs
- Medical records supporting
  - Qualifying test on CMN

- Supporting severe lung disease or hypoxia-related symptoms
- Alternative treatment measures tried or considered and ruled out
- Physician visit within 30 days of initial CMN
- Physician visit with 90 days of revised CMN for Group 1

Enteral Nutrition

- DME Information Form (DIF)
  - Initial DIF
  - Revised DIF
- Medical records supporting:
  - Permanent condition (at least three months in duration)
  - Non-function or disease of the GI Tract (See LCD)
  - Specific conditions examples (not all inclusive)
    - Swallow study
    - Records supporting the condition (stroke, head/neck cancer, etc)

Parenteral Nutrition

- Medical records supporting:
  - Permanent condition (at least three months in duration)
  - Criteria A-F or Criteria G-H have been met
  - Tube trial (if required)

Manual Wheelchairs

- Medical records supporting:
  - Mobility limitation impairing mobility-related activities of daily living (MRADLs)
  - Limitation cannot be resolved with appropriately fitted cane or walker Sufficient upper extremity function
  - Additional criteria for specific manual wheelchairs
- Documentation supporting:
  - Home assessment

Power Mobility Devices (PMD)

- Medical records supporting:
  - Mobility limitation impairing mobility-related activities of daily living (MRADLs)
  - Limitation cannot be resolved with appropriately fitted cane or walker
  - Does not have sufficient upper extremity function to self-propel manual wheelchair
  - Additional criteria for specific PMDs
- Documentation supporting:
  - Home assessment

Orthotics and Prosthetics (Ankle-Foot/Knee-Ankle-Foot Orthoses, Knee Orthoses, Lower Limb Prostheses, Spinal Orthoses)

- Medical records supporting custom vs off the shelf

Vacuum Erection Devices

- Medical records supporting:

- Other modalities have been tried and failed or considered and ruled out

Glucose Monitors and Supplies

- Medical records supporting:
  - Need for high utilization (more than 100 test strips and more than 100 lancets every three months)
  - Treating physician has seen beneficiary within six months for high utilization
  - The beneficiary is actually testing at the frequency dispensed for high utilization

Telephone Reopenings: Resources for Success

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

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

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

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-888-826-5708
What are the hours for Telephone Reopenings?	Monday through Friday 8 a.m. - 4:30 p.m. CT Further closing information can be found at https://www.noridianmedicare.com/dme/contact/holiday.html.
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digit of Tax ID Number (TIN) • Supplier name • Beneficiary's Health Insurance Claim Number (HICN) • Beneficiary's first and last name • Beneficiary's date of birth • Date of service (DOS) • Healthcare Common Procedure Coding System (HCPCS) code(s) in question • Corrective action to be taken **Note:** Claims with remark code MA130 can never be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

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

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

What is not accepted as a Telephone Reopening? (Continued on next page)	The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation. • Overutilization denials that require supporting medical records • Certificate of Medical Necessity (CMN) and Durable Medical Equipment Information Form (DIF) issues. Please see the article posted March 21, 2013, titled "Denied Claims Requiring CMN/DIF Must be Resubmitted, Rather than Reopened" • Oxygen break in service (BIS) issues • Some manual wheelchairs and all power mobility devices (PMDs) – HCPCS K0005 and higher • Overpayments or reductions in payment • Medicare Secondary Payer (MSP) issues • Claims denied for timely filing • Reopenings past one year from the initial determination • Complex Medical Reviews or Additional Documentation Requests • Advance Beneficiary Notice of Noncoverage (ABN) issues and other liability issues • Repair and labor claims • Miscellaneous HCPCS codes and all HCPCS codes that require manual pricing

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? (Continued)	• The following modifier changes or additions:
	  • A1 through A9
	  • K0 through K4
	  • GA
	  • GY
	  • GZ
	  • KX
	  • EY
	  • KG
	  • RA
	  • RB
	  • RP
	• Certain HCPCS codes (not all-inclusive list)
	  • A4450 through A4452
	  • E0194
	  • E0748
	  • E1028
	  • J1559
	  • J1561
	  • J1562
	  • K0108
	  • K0462

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

Rescind/Replace Reclassification of Certain DME from Inexpensive and Routinely Purchased Payment Category to Capped Rental Payment Category – Revised

MLN Matters® Number: MM8566 Revised
Related Change Request (CR) #: CR 8566
Related CR Release Date: December 5, 2014
Effective Date: April 1, 2014
Related CR Transmittal #: R1445OTN
Implementation: April 7, 2014

This article was revised on December 9, 2014, to reflect the revised CR8566 issued on December 5. The CR was revised to add a caret (^) to code E2378 in the table in Attachment A of the CR denoting this is an item which can be billable with complex rehabilitative wheelchair codes K0835-K0864. In the article, the CR release date, transmittal number, and the Web address for accessing CR8566 are revised also. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Home Health & Hospice MACs for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries. **In addition, this MLN Matters® Article is intended to clarify the interaction between these Part B coding changes and the bundled Part A payment that SNFs receive for a resident's Medicare-covered stay.**

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8566 as a one-time notification that provides instructions regarding the reclassification of certain DME from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category for the Healthcare Common Procedure Coding System (HCPCS) codes listed in 'Attachment A' of CR8566. Be sure your billing personnel are aware of these changes.

Background

DME and accessories used in conjunction with DME are paid for under the DME benefit and in accordance with the rules at section 1834(a) of the Social Security Act (the Act). The Medicare definition of routinely purchased durable medical equipment (DME) set forth at 42 CFR 414.220(a)(2) specifies that routinely purchased equipment means equipment that was acquired by purchase on a national basis at least 75 percent of the time during the period July 1986 through June 1987. A review of expensive items that have been classified as routinely purchased equipment since 1989, that is, new codes added to the HCPCS after 1989 for items costing more than $150, showed inconsistencies in applying the definition. As a result, a review of the definition of routinely purchased DME was published in the Federal Register (CMS-1526-F) along with notice of DME items (codes) requiring a revised payment category. CMS-1526-F is available at http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28451.pdf on the Internet.

Also in the rule, CMS established that DME wheelchair accessories that are capped rental items furnished for use as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) are payable under the lump sum purchase method. The complex rehabilitative power wheelchair base codes and options/accessories are payable under the lump sum purchase method set forth at 42 CFR 414.229(a)(5) and section 1834(a)(7)(A)(iii) of the Act.

In order to align the payment category with the required regulatory definition, certain HCPCS codes listed in Attachment A will reclassify from the inexpensive and routinely purchased (IN) DME payment category to the capped rental (CR) DME payment category. Instructions for billing capped rental items can be found at "Medicare Claims Processing Manual" (Pub. 100-04), Chapter 20, Section 130.9 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf along with other sources listed on the CMS and contractor websites.

Be aware the effective date is April 1, 2014 for HCPCS codes not included in a Competitive Bidding Program (CBP) as shown in Attachment A of CR8566. A forthcoming CR will address the codes that are reclassifying to the capped rental payment category effective July 1, 2016, and January 1, 2017.

As shown in the table below, HCPCS codes for items included under the Round 2 and/or Round 1 Recompete DMEPOS CBPs will transition to the capped rental payment category in stages.

Payment Category Transition Effective Dates	
April 1, 2014	HCPCS codes not included in a CBP are reclassified from IN DME to CR DME in all areas
July 1, 2016	HCPCS codes included in a CBP are reclassified from IN DME to CR DME in all areas except the 9 Round 1 Recompete CBAs, where items furnished to beneficiaries residing in these areas will remain in, IN DME through December 31, 2016
January 1,2017	HCPCS codes included in a CBP are reclassified from IN DME to CR DME in the 9 Round 1 Recompete CBAs

When the HCPCS codes listed below are furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete CBP, the payment category transition from inexpensive and routinely purchased to capped rental DME is effective January 1, 2017.

HCPCS for Items Reclassified to Capped Rental DME Category Effective July 1, 2016*	
Support Surfaces	E0197
Walkers	E0140 & E0149
Wheelchairs Options/Accessories	E0985, E1020, E1028, E2228, E2368, E2369, E2370,E2375, K0015, K0070
Wheelchair Seating	E0955

* Items furnished in accordance with Round 1 Recompete contracts reclassify effective January 1, 2017

Complex Rehabilitative Power Wheelchair Accessories

Effective April 1, 2014, for wheelchair accessory codes classified under the capped rental DME payment category and furnished for use with a complex rehabilitative power wheelchair (that is, furnished to be used as part of the complex rehabilitative power wheelchair), the supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished. These accessory items would be considered as part of the complex rehabilitative power wheelchair (codes K0835 – K0864) and associated lump sum purchase option set forth at 42 CFR 414.229(a)(5).

If the beneficiary declines the purchase option, the supplier must furnish the items on a rental basis and payment will be made on a monthly rental basis in accordance with the capped rental payment rules.

Items Needed During a Covered Part A Stay in a SNF

For an SNF resident whose stay is covered by Part A of Medicare, the extended care benefit provides comprehensive coverage for the overall package of institutional care that the SNF furnishes. This coverage includes any medically necessary durable medical equipment (DME) under the heading of ". . . drugs, biologicals, supplies, appliances, and equipment . . ." (section 1861(h)(5) of the Social Security Act (the Act)).

Accordingly, in cases where such a resident has a medical need for DME during the course of the Part A stay, the SNF is obligated to furnish it, since the SNF's global per diem payment for the covered stay itself already includes any medically necessary DME.

Prior to April 1, 2014, and the change in Medicare Part B payment rules addressed in this article, Medicare beneficiaries may have brought this equipment purchased under Part B with them for use during a covered Part A stay in a SNF. This may still be the case for beneficiaries who take over ownership of the equipment after 13 months of continuous Part B rental payments.

However, in those cases where the beneficiary enters a SNF under a covered Part A stay and is in the middle of the 13-month capped rental period under Part B for the item, it is the responsibility of the SNF to ensure that the beneficiary has access to this equipment if it is medically necessary while the beneficiary is in the SNF during the Part A stay.

Additional Information

The official instruction, CR 8566 along with Attachment A, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1445OTN.pdf on the CMS website. Attachment A is also repeated at the end of this article.

Attachment A

Inexpensive & Routinely Purchased (IN) Items Reclassified to Capped Rental (CR)

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
Automatic External Defibrillator	K0607	Repl battery for AED	X		
Canes/Crutches	E0117	Underarm spring assist crutch	X		
Glucose Monitor	E0620	Capillary blood skin piercing device laser	X		
High Frequency Chest Wall Oscillation Device (HFCWO)	A7025	Replace chest compress vest	X		
Hospital Beds/ Accessories	E0300	Enclosed ped crib hosp grade	X		
Misc. DMEPOS	A4639	Infrared ht sys replacement pad	X		
	E0762	Trans elec jt stim dev sys	X		
	E1700	Jaw motion rehab system	X		
Nebulizers & Related Drugs	K0730	Ctrl dose inh drug deliv system	X		
Other Neuromuscular Stimulators	E0740	Incontinence treatment system	X		
	E0764	Functional neuromuscular stimulation	X		
Pneumatic Compression Device	E0656	Segmental pneumatic trunk	X		
	E0657	Segmental pneumatic chest	X		
Power Operated Vehicles	E0984	Add pwr tiller	X		

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
Speech Generating Devices	E2500	SGD digitized pre-rec <=8min	X		
	E2502	SGD prerec msg >8min <=20min	X		
	E2504	SGD prerec msg>20min <=40min	X		
	E2506	SGD prerec msg > 40 min	X		
	E2508	SGD spelling phys contact	X		
	E2510	SGD w multi methods messg/ access	X		
Support Surfaces	E0197 *	Air pressure pad for mattress		X	X
	E0198	Water pressure pad for mattress	X		
Traction Equipment	E0849	Cervical pneum traction equip	X		
	E0855	Cervical traction equipment	X		
	E0856	Cervical collar w air bladder	X		
Walkers	E0140 *	Walker w trunk support		X	X
	E0144	Enclosed walker w rear seat	X		
	E0149 *	Heavy duty wheeled walker		X	X
Wheelchairs Manual (continued on next page)	E1161	Manual adult wc w tiltinspac	X		
	E1232	Folding ped wc tilt-in-space	X		
	E1233	Rig ped wc tltnspc w/o seat	X		
	E1234	Fld ped wc tltnspc w/o seat	X		

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
Wheelchairs Manual (continued)	E1235	Rigid ped wc adjustable	X		
	E1236	Folding ped wc adjustable	X		
	E1237	Rgd ped wc adjstabl w/o seat	X		
	E1238	Fld ped wc adjstabl w/o seat	X		
Wheelchair Options/ Accessories (continued on next page)					
	E0985 *	W/c seat lift mechanism		X	X
	E0986	Man w/c push-rim pow assist	X		
	E1002 ^	Pwr seat tilt	X		
	E1003 ^	Pwr seat recline	X		
	E1004 ^	Pwr seat recline mech	X		
	E1005 ^	Pwr seat recline pwr	X		
	E1006 ^	Pwr seat combo w/o shear	X		
	E1007 ^	Pwr seat combo w/ shear	X		
	E1008 ^	Pwr seat combo pwr shear	X		
	E1010 ^	Add pwr leg elevation	X		
	E1014	Reclining back add ped w/c	X		
	E1020 *	Residual limb support system		X	X
	E1028 *	W/c manual swingaway		X	X
	E1029	W/c vent tray fixed	X		
	E1030 ^	W/c vent tray gimbaled	X		
	E2227	Gear reduction drive wheel	X		
	E2228 *	Mwc acc, wheelchair brake		X	X

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
Wheelchair Options/ Accessories (continued)	E2310 ^	Electro connect btw control	X		
	E2311 ^	Electro connect btw 2 sys	X		
	E2312 ^	Mini-prop remote joystick	X		
	E2313 ^	PWC harness, expand control	X		
	E2321 ^	Hand interface joystick	X		
	E2322 ^	Mult mech switches	X		
	E2325 ^	Sip and puff interface	X		
	E2326 ^	Breath tube kit	X		
	E2327 ^	Head control interface mech	X		
	E2328 ^	Head/extremity control interface	X		
	E2329 ^	Head control interface nonproportional	X		
	E2330 ^	Head control proximity switch	X		
	E2351 ^	Electronic SGD interface	X		
	E2368 *	Pwr wc drivewheel motor replace		X	X
	E2369 *	Pwr wc drivewheel gear box replace		X	X
	E2370 *	Pwr wc dr wh motor/ gear comb		X	X
	E2373 ^	Hand/chin ctrl spec joystick	X		
	E2374 ^	Hand/chin ctrl std joystick	X		
	E2375 *	Non-expandable controller		X	X
	E2376 ^	Expandable controller, replace	X		

Group Category	HCPCS	Descriptor	Effective 4/1/14	Effective 7/1/16 at end of DMEPOS Competitive Bidding Program Round 2	Effective 1/1/17* at end of DMEPOS Competitive Bidding Program Round 1 Recompete
Wheelchair Options/ Accessories (continued)	E2377 ^	Expandable controller, initial	X		
	E2378 ^	Pw actuator replacement	X		
	K0015 *	Detach non-adjus hght armrest		X	X
	K0070 *	Rear whl complete pneum tire		X	X
Wheelchairs Seating	E0955 *	Cushioned headrest		X	X

* Effctive January 1, 2017 if the item is furnished in CBAs in accordance with contracts entered into as part of the Round 1 Recompete of DMEPOS CBP

Item billable with Complex Rehabilitative Power Wheelchair codes K0835 – K0864

2015 Jurisdiction List for DMEPOS HCPCS Codes

Note: Deleted codes are valid for dates of service on or before the date of deletion.

Note: Updated codes are in bold.

Note: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

HCPCS	DESCRIPTION	JURISDICTION
A0021 - A0999	Ambulance Services	Local Carrier
A4206 - A4209	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4210	Needle Free Injection Device	DME MAC
A4211	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4212	Non Coring Needle or Stylet with or without Catheter	Local Carrier
A4213 - A4215	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4216 - A4218	Saline	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4220	Refill Kit for Implantable Pump	Local Carrier
A4221 - A4250	Medical, Surgical, and Self-Administered Injection Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4252 - A4259	Diabetic Supplies	DME MAC
A4261	Cervical Cap for Contraceptive	Local Carrier
A4262 - A4263	Lacrimal Duct Implants	Local Carrier

HCPCS	DESCRIPTION	JURISDICTION
A4264	Contraceptive Implant	Local Carrier
A4265	Paraffin	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4266 - A4269	Contraceptives	Local Carrier
A4270	Endoscope Sheath	Local Carrier
A4280	Accessory for Breast Prosthesis	DME MAC
A4281 - A4286	Accessory for Breast Pump	DME MAC
A4290	Sacral Nerve Stimulation Test Lead	Local Carrier
A4300 - A4301	Implantable Catheter	Local Carrier
A4305 - A4306	Disposable Drug Delivery System	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4310 - A4358	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4360 - A4435	Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450 - A4456	Tape; Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4458-A4459	Enema Bag/System	DME MAC
A4461-A4463	Surgical Dressing Holders	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4465 - A4466	Non-elastic Binder and Elastic Garment	DME MAC
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4483	Moisture Exchanger	DME MAC
A4490 - A4510	Surgical Stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME MAC
A4555 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4559	Coupling Gel	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4561 - A4562	Pessary	Local Carrier
A4565	Sling	Local Carrier

HCPCS	DESCRIPTION	JURISDICTION
A4570	Splint	Local Carrier
A4575	Topical Hyperbaric Oxygen Chamber, Disposable	DME MAC
A4580 - A4590	Casting Supplies & Material	Local Carrier
A4595	TENS Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4600	Sleeve for Intermittent Limb Compression Device	DME MAC
A4601-A4602	Lithium Replacement Batteries	DME MAC
A4604	Tubing for Positive Airway Pressure Device	DME MAC
A4605	Tracheal Suction Catheter	DME MAC
A4606	Oxygen Probe for Oximeter	DME MAC
A4608	Transtracheal Oxygen Catheter	DME MAC
A4611 - A4613	Oxygen Equipment Batteries and Supplies	DME MAC
A4614	Peak Flow Rate Meter	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4615 - A4629	Oxygen & Tracheostomy Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4630 - A4640	DME Supplies	DME MAC
A4641 - A4642	Imaging Agent; Contrast Material	Local Carrier
A4648	Tissue Marker, Implanted	Local Carrier
A4649	Miscellaneous Surgical Supplies	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4650	Implantable Radiation Dosimeter	Local Carrier
A4651 - A4932	Supplies for ESRD	DME MAC (not separately payable)
A5051 - A5093	Additional Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5102 - A5200	Additional Incontinence and Ostomy Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A5500 - A5513	Therapeutic Shoes	DME MAC
A6000	Non-Contact Wound Warming Cover	DME MAC
A6010-A6024	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A6025	Silicone Gel Sheet	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.

HCPCS	DESCRIPTION	JURISDICTION
A6154 - A6411	Surgical Dressing	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A6412	Eye Patch	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A6413	Adhesive Bandage	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A6441 - A6512	Surgical Dressings	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A6513	Compression Burn Mask	DME MAC
A6530 - A6549	Compression Gradient Stockings	DME MAC
A6550	Supplies for Negative Pressure Wound Therapy Electrical Pump	DME MAC
A7000 - A7002	Accessories for Suction Pumps	DME MAC
A7003 - A7039	Accessories for Nebulizers, Aspirators and Ventilators	DME MAC
A7040 - A7041	Chest Drainage Supplies	Local Carrier
A7044 - A7047	Respiratory Accessories	DME MAC
A7048	Vacuum Drainage Supply	Local Carrier
A7501-A7527	Tracheostomy Supplies	DME MAC
A8000-A8004	Protective Helmets	DME MAC
A9150	Non-Prescription Drugs	Local Carrier
A9152 - A9153	Vitamins	Local Carrier
A9155	Artificial Saliva	Local Carrier
A9180	Lice Infestation Treatment	Local Carrier
A9270	Noncovered Items or Services	DME MAC
A9272	Disposable Wound Suction Pump	DME MAC
A9273	Hot Water Bottles, Ice Caps or Collars, and Heat and/or Cold Wraps	DME MAC
A9274 - A9278	Glucose Monitoring	DME MAC
A9279	Monitoring Feature/Device	DME MAC
A9280	Alarm Device	DME MAC
A9281	Reaching/Grabbing Device	DME MAC
A9282	Wig	DME MAC
A9283	Foot Off Loading Device	DME MAC
A9284	Non-electric Spirometer	DME MAC
A9300	Exercise Equipment	DME MAC
A9500 - A9700	Supplies for Radiology Procedures	Local Carrier
A9900	Miscellaneous DME Supply or Accessory	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A9901	Delivery	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
A9999	Miscellaneous DME Supply or Accessory	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
B4034 - B9999	Enteral and Parenteral Therapy	DME MAC
D0120 - D9999	Dental Procedures	Local Carrier
E0100 - E0105	Canes	DME MAC
E0110 - E0118	Crutches	DME MAC
E0130 - E0159	Walkers	DME MAC
E0160 - E0175	Commodes	DME MAC
E0181 - E0199	Decubitus Care Equipment	DME MAC
E0200 - E0239	Heat/Cold Applications	DME MAC
E0240 - E0248	Bath and Toilet Aids	DME MAC
E0249	Pad for Heating Unit	DME MAC
E0250 - E0304	Hospital Beds	DME MAC
E0305 - E0326	Hospital Bed Accessories	DME MAC
E0328 - E0329	Pediatric Hospital Beds	DME MAC
E0350 - E0352	Electronic Bowel Irrigation System	DME MAC
E0370	Heel Pad	DME MAC
E0371 - E0373	Decubitus Care Equipment	DME MAC
E0424 - E0484	Oxygen and Related Respiratory Equipment	DME MAC
E0485 - E0486	Oral Device to Reduce Airway Collapsibility	DME MAC
E0487	Electric Spirometer	DME MAC
E0500	IPPB Machine	DME MAC
E0550 - E0585	Compressors/Nebulizers	DME MAC
E0600	Suction Pump	DME MAC
E0601	CPAP Device	DME MAC
E0602 - E0604	Breast Pump	DME MAC
E0605	Vaporizer	DME MAC
E0606	Drainage Board	DME MAC
E0607	Home Blood Glucose Monitor	DME MAC
E0610 - E0615	Pacemaker Monitor	DME MAC
E0616	Implantable Cardiac Event Recorder	Local Carrier
E0617	External Defibrillator	DME MAC
E0618 - E0619	Apnea Monitor	DME MAC
E0620	Skin Piercing Device	DME MAC
E0621 - E0636	Patient Lifts	DME MAC
E0637 - E0642	Standing Devices/Lifts	DME MAC
E0650 - E0676	Pneumatic Compressor and Appliances	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
E0691 - E0694	Ultraviolet Light Therapy Systems	DME MAC
E0700	Safety Equipment	DME MAC
E0705	Transfer Board	DME MAC
E0710	Restraints	DME MAC
E0720 - E0745	Electrical Nerve Stimulators	DME MAC
E0746	EMG Device	Local Carrier
E0747 - E0748	Osteogenic Stimulators	DME MAC
E0749	Implantable Osteogenic Stimulators	Local Carrier
E0755- E0770	Stimulation Devices	DME MAC
E0776	IV Pole	DME MAC
E0779 - E0780	External Infusion Pumps	DME MAC
E0781	Ambulatory Infusion Pump	Billable to both the local carrier and the DME MAC. This item may be billed to the DME MAC whenever the infusion is initiated in the physician's office but the patient does not return during the same business day.
E0782 - E0783	Infusion Pumps, Implantable	Local Carrier
E0784	Infusion Pumps, Insulin	DME MAC
E0785 - E0786	Implantable Infusion Pump Catheter	Local Carrier
E0791	Parenteral Infusion Pump	DME MAC
E0830	Ambulatory Traction Device	DME MAC
E0840 - E0900	Traction Equipment	DME MAC
E0910 - E0930	Trapeze/Fracture Frame	DME MAC
E0935 - E0936	Passive Motion Exercise Device	DME MAC
E0940	Trapeze Equipment	DME MAC
E0941	Traction Equipment	DME MAC
E0942 - E0945	Orthopedic Devices	DME MAC
E0946 - E0948	Fracture Frame	DME MAC
E0950 - E1298	Wheelchairs	DME MAC
E1300 - E1310	Whirlpool Equipment	DME MAC
E1352 - E1392	Additional Oxygen Related Equipment	DME MAC
E1399	Miscellaneous DME	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
E1405 - E1406	Additional Oxygen Equipment	DME MAC
E1500 - E1699	Artificial Kidney Machines and Accessories	DME MAC (not separately payable)
E1700 - E1702	TMJ Device and Supplies	DME MAC
E1800 - E1841	Dynamic Flexion Devices	DME MAC
E1902	Communication Board	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
E2000	Gastric Suction Pump	DME MAC
E2100 - E2101	Blood Glucose Monitors with Special Features	DME MAC
E2120	Pulse Generator for Tympanic Treatment of Inner Ear	DME MAC
E2201 - E2397	Wheelchair Accessories	DME MAC
E2402	Negative Pressure Wound Therapy Pump	DME MAC
E2500 - E2599	Speech Generating Device	DME MAC
E2601 - E2633	Wheelchair Cushions and Accessories	DME MAC
E8000 - E8002	Gait Trainers	DME MAC
G0008 - G0329	Misc. Professional Services	Local Carrier
G0333	Dispensing Fee	DME MAC
G0337 - G0365	Misc. Professional Services	Local Carrier
G0372	Misc. Professional Services	Local Carrier
G0378 - G9472	Misc. Professional Services	Local Carrier
J0120 - J3570	Injection	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J3590	Unclassified Biologicals	Local Carrier
J7030 - J7131	Miscellaneous Drugs and Solutions	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7178	Fibrinogen	Local Carrier
J7180 - J7195	Antihemophilic Factor	Local Carrier
J7196 - J7197	Antithrombin III	Local Carrier
J7198	Anti-inhibitor; per I.U.	Local Carrier
J7199 - J7201	Other Hemophilia Clotting Factors	Local Carrier
J7300 - J7307	Contraceptives	Local Carrier
J7308 - J7309	Aminolevulinic Acid HCL	Local Carrier
J7310	Ganciclovir, Long-Acting Implant	Local Carrier
J7311 - J7316	Ophthalmic Drugs	Local Carrier
J7321 - J7327	Hyaluronan	Local Carrier
J7330	Autologous Cultured Chondrocytes, Implant	Local Carrier
J7336	Capsaicin	Local Carrier
J7500 - J7599	Immunosuppressive Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
J7799	NOC, Other than Inhalation Drugs through DME	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
J8498	Anti-emetic Drug	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
J8499	Prescription Drug, Oral, Non Chemotherapeutic	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
J8501 - J8999	Oral Anti-Cancer Drugs	DME MAC
J9000 - J9999	Chemotherapy Drugs	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
K0001 - K0108	Wheelchairs	DME MAC
K0195	Elevating Leg Rests	DME MAC
K0455	Infusion Pump used for Uninterrupted Administration of Epoprostenal	DME MAC
K0462	Loaner Equipment	DME MAC
K0552	External Infusion Pump Supplies	DME MAC
K0601 - K0605	External Infusion Pump Batteries	DME MAC
K0606 - K0609	Defibrillator Accessories	DME MAC
K0669	Wheelchair Cushion	DME MAC
K0672	Soft Interface for Orthosis	DME MAC
K0730	Inhalation Drug Delivery System	DME MAC
K0733	Power Wheelchair Accessory	DME MAC
K0738	Oxygen Equipment	DME MAC
K0739	Repair or Nonroutine Service for DME	Local Carrier if implanted DME. If other, DME MAC
K0740	Repair or Nonroutine Service for Oxygen Equipment	DME MAC
K0743 - K0746	Suction Pump and Dressings	DME MAC
K0800 - K0899	Power Mobility Devices	DME MAC
K0900	Custom DME, other than Wheelchair	DME MAC
K0901-K0902	Knee Orthoses	DME MAC
L0112 - L4631	Orthotics	DME MAC
L5000 - L5999	Lower Limb Prosthetics	DME MAC
L6000 - L7499	Upper Limb Prosthetics	DME MAC
L7510 - L7520	Repair of Prosthetic Device	Local Carrier if repair of implanted prosthetic device. If other, DME MAC.
L7600	Prosthetic Donning Sleeve	DME MAC
L7900-L7902	Vacuum Erection System	DME MAC
L8000 - L8485	Prosthetics	DME MAC
L8499	Unlisted Procedure for Miscellaneous Prosthetic Services	Local Carrier if repair of implanted prosthetic device. If other, DME MAC.
L8500 - L8501	Artificial Larynx; Tracheostomy Speaking Valve	DME MAC
L8505	Artificial Larynx Accessory	DME MAC

HCPCS	DESCRIPTION	JURISDICTION
L8507	Voice Prosthesis, Patient Inserted	DME MAC
L8509	Voice Prosthesis, Inserted by a Licensed Health Care Provider	Local Carrier for dates of service on or after 10/01/2010. DME MAC for dates of service prior to 10/01/2010.
L8510	Voice Prosthesis	DME MAC
L8511 - L8515	Voice Prosthesis	Local Carrier if used with tracheoesophageal voice prostheses inserted by a licensed health care provider. If other, DME MAC
L8600 - L8699	Prosthetic Implants	Local Carrier
L9900	Miscellaneous Orthotic or Prosthetic Component or Accessory	Local Carrier if used with implanted prosthetic device. If other, DME MAC.
M0075 - M0301	Medical Services	Local Carrier
P2028 - P9615	Laboratory Tests	Local Carrier
Q0035	Influenza Vaccine; Cardio-kymography	Local Carrier
Q0081	Infusion Therapy	Local Carrier
Q0083 - Q0085	Chemotherapy Administration	Local Carrier
Q0091	Smear Preparation	Local Carrier
Q0092	Portable X-ray Setup	Local Carrier
Q0111 - Q0115	Miscellaneous Lab Services	Local Carrier
Q0138-Q0139	Ferumoxytol Injection	Local Carrier
Q0144	Azithromycin Dihydrate	Local Carrier if incident to a physician's service. If other, DME MAC.
Q0161 - Q0181	Anti-emetic	DME MAC
Q0478 - Q0509	Ventricular Assist Devices	Local Carrier
Q0510 - Q0514	Drug Dispensing Fees	DME MAC
Q0515	Sermorelin Acetate	Local Carrier
Q1004 - Q1005	New Technology IOL	Local Carrier
Q2004	Irrigation Solution	Local Carrier
Q2009	Fosphenytoin	Local Carrier
Q2017	Teniposide	Local Carrier
Q2026-Q2028	Injectable Dermal Fillers	Local Carrier
Q2034 - Q2039	Influenza Vaccine	Local Carrier
Q2043	Sipuleucel-T	Local Carrier
Q2049-Q2050	Doxorubicin	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
Q3001	Supplies for Radiology Procedures	Local Carrier
Q3014	Telehealth Originating Site Facility Fee	Local Carrier
Q3027 - Q3028	Vaccines	Local Carrier

HCPCS	DESCRIPTION	JURISDICTION
Q3031	Collagen Skin Test	Local Carrier
Q4001 - Q4051	Splints and Casts	Local Carrier
Q4074	Inhalation Drug	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
Q4081	Epoetin	Local Carrier
Q4082	Drug Subject to Competitive Acquisition Program	Local Carrier
Q4100 - Q4160	Skin Substitutes	Local Carrier
Q5001 - Q5010	Hospice Services	Local Carrier
Q9951 - Q9954	Imaging Agents	Local Carrier
Q9955 - Q9957	Microspheres	Local Carrier
Q9958 - Q9969	Imaging Agents	Local Carrier
R0070 - R0076	Diagnostic Radiology Services	Local Carrier
V2020 - V2025	Frames	DME MAC
V2100 - V2513	Lenses	DME MAC
V2520 - V2523	Hydrophilic Contact Lenses	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
V2530 - V2531	Contact Lenses, Scleral	DME MAC
V2599	Contact Lens, Other Type	Local Carrier if incident to a physician's service or used in an implanted infusion pump. If other, DME MAC.
V2600 - V2615	Low Vision Aids	DME MAC
V2623 - V2629	Prosthetic Eyes	DME MAC
V2630 - V2632	Intraocular Lenses	Local Carrier
V2700 - V2780	Miscellaneous Vision Service	DME MAC
V2781	Progressive Lens	DME MAC
V2782 - V2784	Lenses	DME MAC
V2785	Processing--Corneal Tissue	Local Carrier
V2786	Lens	DME MAC
V2787 - V2788	Intraocular Lenses	Local Carrier
V2790	Amniotic Membrane	Local Carrier
V2797	Vision Supply	DME MAC
V2799	Miscellaneous Vision Service	DME MAC
V5008 - V5299	Hearing Services	Local Carrier
V5336	Repair/Modification of Augmentative Communicative System or Device	DME MAC
V5362 - V5364	Speech Screening	Local Carrier

DMEPOS Fee Schedule – Update for 2015 – Revised

MLN Matters® Number: MM8999
Revised Related Change Request (CR) #: CR 8999
Related CR Release Date: February 6, 2015
Effective Date: January 1, 2015
Related CR Transmittal #: R3190CP
Implementation Date: January 5, 2015

This article was revised on February 24, 2015, to reflect the revised CR8999 issued on February 6. In the article, the CR release date, transmittal number, and the Web address for accessing the CR were updated. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8999 to advise providers of the CY 2015 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 staffs are aware of these updates.

Background

CMS updates the DMEPOS fee schedules 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, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section 1834(a), (h), and (i) of the Social Security Act (the Act). 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.

Key Points

Fee Schedule Files

The DMEPOS fee schedule file will be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ on the CMS website.

Healthcare Common Procedure Coding System (HCPCS) Codes Added/ Deleted

The following new codes are effective January 1, 2015:

- A4602 in the inexpensive/routinely purchased (IN) payment category;
- The following new codes are in the prosthetics and orthotics (PO) payment category: A7048, L3981, L6026, L7259, and L8696. (Fee schedule amounts for these codes will be added to the DMEPOS fee schedule, effective January 1, 2015.); and
- Also, code A4459 is added.

The base fee for code A4602 will be submitted to CMS by CMS contractors by April 3, 2015, for inclusion in the July 2015 DMEPOS fee schedule update.

The following codes are deleted from the DMEPOS fee schedule files effective January 1, 2015: A7042, A7043, L6025, L7260, and L7261.

For gap-filling purposes, the 2014 deflation factors by payment category are in the table below.

Factor	Category
0.459	Oxygen
0.462	Capped Rental
0.464	Prosthetics and Orthotics
0.588	Surgical Dressings
0.640	Parenteral and Enteral Nutrition
0.963	Intraocular Lenses
0.980	Splints and Casts

Specific Coding and Pricing Issues

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 in order to reflect more current allowed service data. 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 2015, 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 the calendar year 2013.

The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2015.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order diabetic testing supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the single payment amounts for mail order DTS established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act.

The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are re-competed. The national competitive bidding program for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016.

The program instructions reviewing the changes are in Transmittal 2661, CR8204, dated February 22, 2013. The MLN Matters® article related to CR8204 is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf on the CMS website.

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 such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.5 percent for CY 2015. The single payment amount public use file for the national mail order competitive bidding program is available at http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

2015 Fee Schedule Update Factor of 1.5 Percent

For CY 2015, the update factor of 1.5 percent is applied to the applicable CY 2014 DMEPOS 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 2015 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 2014, 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-Factor Productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.1 percent. Thus, the 2.1 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 1.5 percent for the update factor.

2015 Update to the Labor Payment Rates

The table below contains the CY 2015 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the 12-month period ending with June 30, 2014, is 2.1 percent this change is applied to the 2014 labor payment amounts to update the rates for CY 2015.

The 2015 labor payment amounts in the following table are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2015, through December 31, 2015.

STATE	K0739	L4205	L7520
AK	$27.98	$31.88	$37.50
AL	14.86	22.14	30.05
AR	14.86	22.14	30.05
AZ	18.37	22.11	36.97
CA	22.79	36.34	42.35
CO	14.86	22.14	30.05
CT	24.81	22.63	30.05
DC	14.86	22.11	30.05
DE	27.35	22.11	30.05
FL	14.86	22.14	30.05
GA	14.86	22.14	30.05
HI	18.37	31.88	37.50
IA	14.86	22.11	35.97
ID	14.86	22.11	30.05
IL	14.86	22.11	30.05
IN	14.86	22.11	30.05
KS	14.86	22.11	37.50
KY	14.86	28.34	38.43
LA	14.86	22.14	30.05
MA	24.81	22.11	30.05
MD	14.86	22.11	30.05
ME	24.81	22.11	30.05
MI	14.86	22.11	30.05
MN	14.86	22.11	30.05
MO	14.86	22.11	30.05
MS	14.86	22.14	30.05
MT	14.86	22.11	37.50

STATE	K0739	L4205	L7520
NC	$14.86	$22.14	$30.05
ND	18.51	31.81	37.50
NE	14.86	22.11	41.90
NH	15.95	22.11	30.05
NJ	20.04	22.11	30.05
NM	14.86	22.14	30.05
NV	23.67	22.11	40.96
NY	27.35	22.14	30.05
OH	14.86	22.11	30.05
OK	14.86	22.14	30.05
OR	14.86	22.11	43.21
PA	15.95	22.77	30.05
PR	14.86	22.14	30.05
RI	17.70	22.79	30.05
SC	14.86	22.14	30.05
SD	16.60	22.11	40.18
TN	14.86	22.14	30.05
TX	14.86	22.14	30.05
UT	14.90	22.11	46.79
VA	14.86	22.11	30.05
VI	14.86	22.14	30.05
VT	15.95	22.11	30.05
WA	23.67	32.44	38.53
WI	14.86	22.11	30.05
WV	14.86	22.11	30.05
WY	20.71	29.50	41.90
WY	20.71	29.50	41.90

2015 National Monthly Payment Amounts for Stationary Oxygen Equipment

As part of CR8999, CMS is implementing the 2015 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2015. Included is the updated national 2015 monthly payment amount of $180.92 for stationary oxygen equipment codes in the DMEPOS fee schedule. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). Also, the updated 2015 monthly payment amount of $180.92 includes the 1.5 percent update factor for the 2015 DMEPOS fee schedule. Thus, the 2014 rate changed from $178.24 to the 2015 rate of $180.92.

When updating the stationary oxygen equipment fees, 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 fees 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.

2015 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2015 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment instructions for claims for maintenance and servicing of oxygen equipment are in Transmittal 635, CR6792, dated February 5, 2010, (see the article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf) and Transmittal 717, CR6990, dated June 8, 2010, (see the related article at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf).

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 Section 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 Section 1834(a)(14) of the Act. Thus, the 2014 maintenance and servicing fee is adjusted by the 1.5 percent MFP-adjusted covered item update factor to yield a CY 2015 maintenance and servicing fee of $69.76 for oxygen concentrators and transfilling equipment.

Update to Change Request (CR) 8566

Effective April 1, 2014, payment on a purchase basis was established for capped rental wheelchair accessory codes furnished for use with complex rehabilitative power wheelchairs. Such accessories are considered as part of the complex rehabilitative power wheelchair and associated lump sum purchase option set forth at 42 CFR Section 414.229(a)(5). These changes were implemented in Transmittal 1332, CR8566, dated January 2, 2014. Code E2378 is added to the list of codes eligible for payment on a purchase basis when furnished for use with a complex rehabilitative power wheelchair.

Additional Information

The official instruction for CR8999 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3190CP.pdf on the CMS website

HPTC 2015 Update

MLN Matters® Number: MM8993
Related Change Request (CR) #: CR 8993
Related CR Release Date: February 20, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3201CP
Implementation Date: As soon as April 1, 2015, but no later than July 6, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8993 instructs MACs to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and use it to update their internal HPTC tables and/or reference files.

Background

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

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

You should note that:

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

CR 8993 implements the NUCC HPTC code set that is effective on April 1, 2015, and instructs MACs to obtain the most recent HPTC set and use it to update their internal HPTC tables and/or reference files. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at http://www.wpc-edi.com/codes on the Internet.

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

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

Additional Information

The official instruction, CR 8993, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3201CP.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

BILLING

Improper Submission of Item 23 May Cause Claim Denials

When submitting DME claims, please ensure that information is not entered, unless required per Medicare claims processing guidance, in Item 23 on the paper claim form or the electronic equivalent, the 2300 loop, REF02 segment with REF01=G1 or loop 2400 REF02 segment with REF01=G1.

For DME claims, these fields are only used for the Prior Authorization Number or Unique Tracking Number (UTN) for Power Mobility Device (PMD) demonstration claims. Entering other extraneous information may cause claim denials or delays in claim processing.

Suppliers are also reminded that the PMD Prior Authorization demonstration program is only applicable to beneficiaries who live in a demonstration state (currently for Jurisdiction D these are the states of Arizona, California, Missouri and Washington) and only for certain PMD base codes, not including accessory codes.

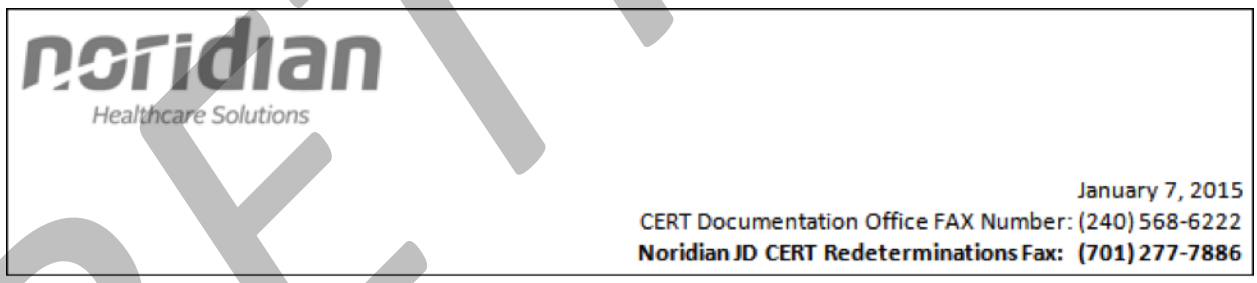
Currently, the following HCPCS codes are subject to the PMD prior authorization process:

- Group 1 Power Operated Vehicles (K0800-K0802 and K0812)
- All standard power wheelchairs (K0813 through K0829)
- All Group 2 complex rehabilitative power wheelchairs (K0835 through K0843)
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 through K0855)
- Pediatric power wheelchairs (K0890-K0891)
- Miscellaneous power wheelchairs (K0898)

CERT

CERT Denial Options: Additional Documentation or Appeal

Noridian provides faxes to suppliers explaining Comprehensive Error Rate Testing (CERT) Review Contractor denial comments when CERT has denied a claim. When the denial comments are sent to the supplier, there are two fax numbers listed on the top right hand side of the fax. These fax numbers are for the supplier to utilize if they wish to proceed with their denial.


noridian
Healthcare Solutions

January 7, 2015
CERT Documentation Office FAX Number: (240) 568-6222
Noridian JD CERT Redeterminations Fax: (701) 277-7886

For CERT denials, the supplier has two options presented to them on the fax:

1. Fax all newly obtained documentation to the CERT Documentation Office fax number listed at the top of this page; or
2. Complete the Medicare DME Redetermination Request Form. Fax the form and all documentation to support the claim (i.e., newly obtained documentation AND previously submitted documentation) to the **Noridian JD redeterminations fax number** listed at the top of this page. **Note:** Please include the CERT Identification Number (CID) on the submitted redetermination form to assist with processing of the appeal.

For option one listed above, the supplier only sends in the missing documentation to the CERT Documentation Office for consideration of payment by the CERT Review Contractor. If this option is chosen by the supplier, the supplier is only notified of a CERT overturned claim. If the claim is found to remain denied, the supplier is not notified.

For option two listed above, the supplier files an appeal with Noridian following the same process as a claim denial. The supplier sends in all documentation to support the billed claim. The supplier is notified of the outcome of the appeal by the remittance advice for a fully favorable decision or a letter if found partially favorable or denied. If the claim remains denied, the supplier has appeal rights to go onto the next level of appeals.

The supplier should never send documentation back to the CERT fax number they received the denial comments on. This fax number is not for appealed claims and information sent here is in error. To have your claim reviewed appropriately, ensure the above steps are followed and the documentation is sent to the correct location.

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.

Claims Selected for CERT Review Following Affirmed Prior Authorization Request

Claims with an affirmed Prior Authorization Request (PAR) on file have the potential to be reviewed, and subsequently denied, by other entities such as the Comprehensive Error Rate Testing (CERT) program, Zone Program Integrity Contractors (ZPICs), or other reviewing bodies.

The PAR demonstration for select power mobility device (PMD) codes was implemented for beneficiaries residing in seven states in September 2012 with expansion to 12 additional states in October 2014.

The demonstration allows suppliers to submit documentation to the contractors to determine if policy and medical necessity requirements have been met prior to providing the PMD to the beneficiary.

It is important for suppliers to note that an affirmed PAR does not exclude the subsequent PMD claims from CERT review in the future.

The CERT Review Contractor could potentially request the documentation that supports the payment of the PMD, even with an affirmed PAR on file. When this occurs, the supplier is expected to respond by providing the requested documentation supporting the PMD billed. Sending the affirmed PAR decision letter alone is not sufficient for CERT review.

If selected for CERT review following a PAR affirmation, Noridian encourages suppliers to send in all the documentation that was submitted with the affirmed PAR in addition to the home assessment and proof of delivery (POD). The home assessment and POD are not requirements for PAR review, but are required for a complete claim review.

Noridian also reminds suppliers to include the correct ordering practitioner's National Provider Identifier (NPI) on the claim when billing. The NPI billed on the claim should be that of the practitioner who completed the face-to-face examination and the 7-Element Order.

CODING

Correct Coding – Cast Covers

Joint DME MAC

Recently the DME MACs have received inquiries about coverage of covers for casts. These are typically constructed of latex or rubber and are designed to fit over a cast to allow bathing, showering or swimming without water infiltration. Medicare considers cast covers a convenience item; therefore, these items are non-covered. The proper HCPCS code for cast covers is:

A9270 – Non-covered item or service

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.

Coverage and Correct Coding of HyQvia®

Joint DME MAC Publication

On September 12, 2014, HyQvia® (Baxter) was approved by the FDA for the treatment of primary immunodeficiency (PI) in adults. HyQvia® is a recombinant human hyaluronidase-facilitated subcutaneous infusion of human immunoglobulins. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have evaluated HyQvia® and determined that it is not eligible for inclusion in the DME External Infusion Pump Local Coverage Determination (LCD).

Claims for HyQvia® will be denied as discussed in a joint DME MAC bulletin article that was posted on June 24, 2011, titled "Drugs Used With External Infusion Pumps - Coverage and Billing Reminders." That article described various infusion drug and pump billing scenarios and stated, in pertinent part:

- Billing for an infusion drug alone (no pump being used). There is no statutory infusion drug benefit to allow coverage. All infusion drugs and any associated supplies will be denied as statutorily non-covered.
- Billing for a pump with an infusion drug not listed in the LCD. The External Infusion Pump is periodically updated to list specific drugs eligible for coverage. Drugs not listed in the LCD, including the associated pump and supplies, will be denied as not reasonable and necessary. HyQvia® will not be added to the LCD as a covered drug.

Please refer to the entire bulletin article referenced above, the External Infusion Pump LCD and related Policy Article for additional information.

Claims for HyQvia® for dates of service on or after September 12, 2014, must be submitted using the DME miscellaneous code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

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

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

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.

HCPCS Code Update – 2015

The following list identifies changes to level II Healthcare Common Procedure Coding System (HCPCS) codes for 2015.

Added Codes: New codes are effective for dates of service on or after January 1, 2015.

Discontinued Codes: Codes or modifiers that are discontinued will continue to be valid for claims with dates of service on or before December 31, 2014, regardless of the date of claim submission. If there is a direct crosswalk for a discontinued/deleted code or modifier, it is listed in the table. The crosswalked codes are also "added" codes effective for dates of service on or after January 1, 2015.

There is no grace period that would allow submission of the discontinued code for dates of service in 2015.

Narrative Changes: A description change for an existing code is effective for dates of service on or after January 1, 2015.

The appearance of a code in this list does not necessarily indicate coverage.

Cervical Traction Devices

Narrative Changes

Code	Old Narrative	New Narrative
E0856	Cervical traction device, cervical collar with inflatable air bladder	Cervical traction device, with inflatable air bladder(s)

External Infusion Pumps

Added Code

Code	Narrative
A4602	Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each
J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10mg

Discontinued Code

Code	Narrative	Crosswalk to Code
J2271	Injection, morphine sulfate, 100mg	J2270
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg	J2274

Immunosuppressive Drugs

Added Code

Code	Narrative
Q2052	Services, supplies and accessories used in the home under the Medicare Intravenous Immune Globulin (IVIG) Demonstration (Effective 4/1/2014)

Knee Orthoses

Added Code

Code	Narrative
K0901	Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Effective 10/1/2014)
K0902	Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Effective 10/1/2014)

Power Wheelchair

Narrative Changes

Code	Old Narrative	New Narrative
E0986	Manual wheelchair accessory, push activated power assist, each	Manual wheelchair accessory, push-rim activated power assist system

Miscellaneous

Added Code

Code	Narrative
A4459	Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type
A4601	Lithium ion battery, rechargeable, for non-prosthetic use, replacement

Refractive Lenses

Narrative Changes

Code	Old Narrative	New Narrative
V2799	Vision service, miscellaneous	Vision item or service, miscellaneous

Upper Limb Orthotics

Added Code

Code	Narrative
L3981	Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments

Upper Limb Prosthetics

Added Code

Code	Narrative
L6026	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal
L7259	Electronic wrist rotator, any type

Discontinued Code

Code	Narrative	Crosswalk to Code
L6025	Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device	L6026
L7260	Electronic wrist rotator, otto bock or equal	L7259
L7261	Electronic wrist rotator, any type	L7259

Narrative Changes

Code	Old Narrative	New Narrative
L7367	Lithium ion battery, replacement	Lithium ion battery, rechargeable, replacement

Correct Coding and Coverage – Peristeen® Transanal Irrigation System

Joint DME MAC Publication

The Peristeen® transanal irrigation system is a device used to empty the lower bowel and to prevent chronic constipation and fecal incontinence or simply as a method of bowel management. The system consists of an enema bag, a rectal catheter with an inflatable balloon and pump. Effective for claims with dates of service on or after January 1, 2015, the correct code to bill is:

A4459 – MANUAL PUMP ENEMA SYSTEM, INCLUDES BALLOON, CATHETER AND ALL ACCESSORIES, REUSABLE, ANY TYPE

There is no Medicare benefit for this device; therefore, claims for code A4459 will be denied as non-covered (no Medicare benefit).

Code A4459 is an all-inclusive code at initial issue. Separate billing of any of the individual components is not allowed. The code is established as a single code to include all parts including the disposable supplies at initial issue. For refills of disposable supplies such as rectal catheters, HCPCS code A9270 (Noncovered item or service) should be used.

For questions about correct coding, contact the Pricing, Data Analysis, 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 – Fitness Monitoring Technologies

Joint DME MAC & PDAC Publication

Recently the DME MACs have received inquiries about coverage of fitness and rehabilitation tracking (FRT) technologies such as the FitBit®, WeGo®, Fuelband® and other devices such as pedometers, heart rate monitors, and GPS watches. FRTs are typically worn on the wrist and monitor the amount of exercise and movement of the wearer. FRTs are considered exercise equipment and are non-covered by Medicare. Suppliers billing FRTs must use HCPCS code A9300 (Exercise Equipment).

For questions about correct coding, contact the PDAC Contact Center at (877) 735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or e-mail the PDAC by completing the DME PDAC Contact Form.

Coverage and Correct Coding of Continuous Glucose Monitoring Devices

Revised December 2014

Joint DME MAC Publication

This article was originally posted July 24, 2014. It is revised to allow for separate billing of supplies used with CGMs.

Continuous glucose monitoring (CGM) devices measure glucose in the interstitial fluid, not capillary blood, providing interstitial glucose readings every few minutes. CGM systems are composed of several components - disposable sensors that are inserted in the subcutaneous tissue, a transmitter that relays information to the receiver, and a receiver where the information is displayed.

Coverage

Current CGM systems are FDA-approved only as a secondary source for glucose monitoring. According to the FDA labeled indications, all CGM device readings must be confirmed with a capillary blood glucose monitor and users are cautioned against making insulin dosage changes based solely on CGM system determinations. Consequently, CGM devices are considered precautionary equipment. The Medicare Durable Medical Equipment Benefit excludes precautionary items from coverage; therefore, claims for CGM systems are denied as statutorily non-covered, no benefit.

Medicare covers necessary supplies used with covered items. When the base item is non-covered, the related supplies are also not covered. Claims for supplies used with CGM systems are denied as statutorily non-covered, no benefit.

Coding

CGM systems are provided either as complete stand-alone systems or with one or more components integrated into an external insulin infusion pump. For stand-alone systems and related supplies, use the following HCPCS codes:

A9276 - SENSOR; INVASIVE (E.G. SUBCUTANEOUS), DISPOSABLE, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM, ONE UNIT = 1 DAY SUPPLY

A9277 - TRANSMITTER; EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

A9278 - RECEIVER (MONITOR); EXTERNAL, FOR USE WITH INTERSTITIAL CONTINUOUS GLUCOSE MONITORING SYSTEM

The following HCPCS codes are used for insulin pumps and related supplies:

E0784 - EXTERNAL AMBULATORY INFUSION PUMP, INSULIN
A4221 - SUPPLIES FOR MAINTENANCE OF DRUG INFUSION CATHETER, PER WEEK (LIST DRUG SEPARATELY)

K0552 - SUPPLIES FOR EXTERNAL DRUG INFUSION PUMP, SYRINGE TYPE CARTRIDGE, STERILE, EACH

Billing

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have received multiple inquiries regarding correct coding for integrated products with multiple functions, each with a separate HCPCS code.

For CGM capability that is integrated into an insulin pump, the receiver/monitor (A9278) is considered as included in the coding for the infusion pump. There is no separate or additional coding for the integrated CGM receiver/monitor. Claims for separate billing will be denied as unbundling.

For CGM capability integrated into an external insulin infusion pump, the transmitter and supplies for CGM use are separately billable. Supplies are billed using code A9276. Code A9277 should be used for the non-integrated transmitter. Claims for CGM supplies and non-integrated system components will be denied as statutorily non-covered, no benefit.

Refer to the LCDs and related Policy Articles for Glucose Monitors and External Infusion Pumps for additional information.

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

CMS Announces Timeline for the DMEPOS Competitive Bidding Round 2 Recompete/National Mail-Order Recompete

DMEPOS Competitive Bidding - Bidder Education Program Begins

Bidding Timeline

CMS has announced the bidding timeline for the Round 2 Recompete and the national mail-order recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program.

Bidder Education Program

CMS has also launched a comprehensive bidder education program. This program is designed to ensure that DMEPOS suppliers interested in bidding receive the information and assistance they need to submit complete bids in a timely manner.

The CBIC is the official information source for bidders and the focal point for bidder education. The CBIC website features an array of important and helpful information for suppliers, including bidding rules, user guides, fact sheets, checklists, and bid preparation worksheets.

The education program also includes a new video series to assist and guide bidders through the entire bidding process. The short – but helpful and engaging – instructional videos are posted on the CBIC website. When a new video is posted, the CBIC will announce its availability through a CBIC e-mail update. To sign up to receive video announcements and other key registration and bidding information, subscribe to CBIC E-Mail Updates.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 1-877-577-5331, with questions. During registration and bidding periods, the customer service center will be open from 9am to 9pm ET.

For More Information:

- Press Release
- Fact Sheet

Competitive Bid Wheelchair Accessory Billing on Non-Bid Base Units

In Medlearn Matters 8864, Scenario 2 indicated the fee schedule amount (5%) for the wheelchair accessory would be paid. Noridian had previously reported that we would be adjusting claims that fall under this scenario; however we have found that suppliers will need to request claim adjustments, as outlined below. (Scenario 2 is listed at the end of this article for reference).

Suppliers were not previously instructed to bill KY modifier for these claims. Therefore, suppliers will need to call telephone reopenings or submit a written reopening request to request that a KY modifier be added to the claim to allow these claims to pay correctly at the fee schedule amount.

If you have a large number of claims that fall under this scenario and you can provide a listing, please call telephone reopenings to discuss handling this as a special project.

Below are definitions of the KE and KY modifiers to help you determine whether these apply to your claim and to help with proper usage of these modifiers:

KE-DMEPOS Item Subject to DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment

KY- CB wheelchair accessory used with non-CB wheelchair base

Note: For new claims that meet the criteria described above, bill with both a KE and KY modifier to receive the fee schedule payment.

Scenario #2:

- Wheelchair accessory is competitively bid in Round 1 and Round 2
- Billed for use with **a non-competitively bid base unit that was not bid in Round 1 or Round 2** (HCPCS codes K0005, K0009, K0898, E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, and E1239)
- Billed with modifiers "KE" **and** "KY"
- Billed by a contract or non-contract supplier
- For a beneficiary that resides in a Competitive Bid Area (CBA)

Competitively Bid Wheelchair Accessories: Guidance on Claims Billing and Processing – Effective January 5, 2015

The CMS issued Change Request (CR) 8864 which provided guidance regarding CMS claims billing and processing instructions for competitively bid wheelchair accessories furnished for use with non-competitively bid wheelchair base units to beneficiaries residing in a Competitive Bidding Area (CBA). The CR will implement corrections within the VIPS Medicare system (VMS) which will allow for correct processing and payment of these claims. The changes outlined in the CR will be implemented by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) on January 5, 2015, and will be effective for claims processed on or after January 5, 2015.

Shortly after January 5, 2015, Noridian will be identifying claims paid incorrectly for contract suppliers or denied for non-contract suppliers and will be adjusting accordingly, per the updates outlined in CR8864. Timely filing denials will not be applied to these adjusted claims. Suppliers will not need to do anything further for claims billed to Jurisdiction D.

Noridian anticipates that all claims will be adjusted and finalized by February 13, 2015. Beginning on February 16, if you feel that you have claims that were not reprocessed for the changes outlined in CR8864 and you have verified that a **claim is not pending** by using the Interactive Voice Response (IVR) or our Internet portal, Endeavor, contact Noridian's contact center with the claim examples. We will then advise you on the most appropriate next step.

For more information, see MLN Matters 8864.

DMEPOS Competitive Bidding: Only Two Weeks Until the Covered Document Review Date

Financial documents must be received by February 23

Reminder: If you are a supplier bidding in the Round 2 Recompete and/or the national mail-order recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, the Competitive Bidding Implementation Contractor (CBIC) must receive your hardcopy financial documents on or before February 23, 2015 in order for the documents to be eligible for a covered document review and for you to be notified of any missing financial documents. Don't wait – send the required hardcopy financial documents today.

All suppliers bidding in the Medicare DMEPOS Competitive Bidding Program must submit the financial documents specified in the Request for Bids (RFB) instructions. CMS urges all bidders to take advantage of the covered document review process. Under this process, bidders whose financial documents are received by the CBIC by the covered document review date (CDRD) will be notified of any missing financial documents and will have an opportunity to submit the missing documents.

The CDRD deadline for the Round 2 Recompete and the national mail-order recompete is February 23, 2015 – financial documents must be received by CBIC on or before February 23, 2015, to qualify for the covered document review process.

The covered document review process is only to determine if individual financial documents are missing and is not a review of the accuracy or completeness of individual documents. Bidders whose hardcopy financial documents are received by the CBIC by the CDRD will be notified of any missing financial documents within 90 days of the CDRD. Bidders will be required to submit only the indicated missing financial document(s) within 10 business days of the notification. Bidders whose hardcopy financial documents are received after the CDRD will not be notified of any missing financial documents. After the bid window closes, bidders may only submit the requested financial documents identified as part of the CDRD process and cannot submit corrections to any other required documents. Bidders are encouraged to review the Covered Document Review Date fact sheet on the CBIC website.

Here are some important instructions to remember when submitting your financial documents:

- Review the RFB carefully to be sure that your financial documents comply with all requirements. The RFB contains complete instructions for compiling and submitting your financial documents.
- Put your bidder number on every page of every document. CMS needs your bidder number to match your hardcopy documents with your electronic bid. You will get your bidder number when you complete the Business Organization Information screen in Form A in DBidS, the online bidding system.
- Submit all required hardcopy documents in one package.

For more information on the hardcopy document requirement and about the CDRD, please watch this short, educational video: Submitting Hardcopy Documents.

The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under the Educational Information section of the Round 2 Recompete & National Mail-Order Recompete page.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 1-877-577-5331, with their questions. During registration and bidding periods, the customer service center will be open from 9am to 9pm prevailing ET.

DMEPOS Competitive Bidding Program: Additional Instructions for Grandfathered Items

MLN Matters® Number: MM9060
Related Change Request (CR) #: CR 9060
Related CR Release Date: February 13, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1470OTN
Implementation Date: July 6, 2015

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for grandfathered DMEPOS items provided to Medicare beneficiaries under the competitive bidding program.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9060 to make certain that your DME MACs adjust their systems as necessary to process and pay claims from grandfathered DME suppliers for certain items subject to the CBP, including capped rental items, and oxygen supply items. Make certain your billing staffs are aware of these changes.

Background

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

Under the program, CMS conducts a competition among suppliers who operate in a particular Competitive Bidding Area (CBA). 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.

The following policies detail the CR9050 instructions for grandfathered DME items:

Accessories for Capped Rental Items

A grandfathered supplier with claims for accessories with a date of service during the rental period of the grandfathered equipment is entitled to payment at the single payment amount regardless the status of the Certificate of Medical Necessity (CMN) when the claim is submitted (provided timely filing requirements are met). DME MACs will make changes in order to pay in accordance with this policy.

Advance Beneficiary Notice (ABN)

If an Original Medicare beneficiary living in a CBA opts to receive their competitively bid items and supplies from a non-contract supplier, they can indicate that preference by signing an ABN. The DME MAC should allow the claims to process, but deny the with a Patient Responsibility (PR) group code so the beneficiary is financially responsible for the claim.

The GA modifier indicates that the beneficiary has signed an ABN for the item or supply.

The following remark and reason codes will be used when denying a claim for a competitive bid item obtained from a non-contract supplier, when the supplier has obtained an ABN from the beneficiary:

- N211: Alert: You may not appeal this decision.;
- 96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; and
- M38: The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.

Group Code: PR – Patient Responsibility

Grandfathering: Changing Locations

Medicare allows a new 13-month capped rental period when a beneficiary receiving a capped rental item from a grandfathered supplier elects to transition to a contract supplier prior to the 13th month of rental. Medicare also allows a contract supplier to receive 10 monthly rental payments if a beneficiary receiving oxygen items from a grandfathered supplier elects to transition to a contract supplier prior to the 36th month of rental but after the 27th month of rental. If the 10 monthly rental payments are not complete prior to the end of the round and the beneficiary elects to switch again to a new contract supplier for the subsequent round, the new contract supplier will be paid the remainder of the 10 monthly rental payments. The additional payments are not payable if a beneficiary switches from a contract supplier to another contract supplier. The additional payments are payable if a beneficiary switches from a non-contract supplier (grandfathered) to a contract supplier even if it occurs between rounds.

Contract suppliers may designate certain locations as contract supplier locations and other locations that serve as a non-contract grandfather location. In any grandfathering situation, when a beneficiary switches from a grandfathered supplier (non-contract) location to a contracted location of the same or related supplier that contract supplier is not entitled to the additional payments. Simply changing the location that was furnishing the grandfathered item to a contracted location of a related supplier does not entitle the contracted supplier to additional payments.

Processing Grandfathering Claims at the 6-Digit Provider Transaction Access Number (PTAN) Level

Currently, if a non-contracted supplier provides a competitive bid item to a competitive bid beneficiary as a grandfathered supplier and then transitions the beneficiary to another related non-contracted location (that is, both locations share the same Employee Identification number and the first six-digits of their PTAN), the new location would be eligible for payment as a grandfathered supplier. Medicare's claims processing system needs to allow for payment if there is a match between the billing supplier and the supplier on the CMN at the six-digit PTAN level as opposed to the 10-digit PTAN. Once the system is updated, a related location of the grandfathered supplier can receive payment for the equipment's remaining rental months in place of the original grandfathered supplier.

Determining the Appropriate Payment Amount for a Grandfathered Item

Payment for grandfathered items is dependent upon whether or not the item was previously included in a competitive bidding round. In order to correctly determine the payment amount for grandfathered items, Medicare's claims processing system needs to identify grandfathered claims using a combination of ZIP Code and HCPCS code. Currently, that system identifies grandfathered claims by CBA, HCPCS code, and HCPCS modifier which can cause processing errors if the identifier used for the CBA changes (from one round to another) or if a HCPCS modifier requirements change.

Additional Information

The official instruction for CR9060 issued to your DME MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1470OTN.pdf on the CMS website.

"The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Grandfathering Requirements for Non-Contract Suppliers" should be review at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Grandfathering_Factsheet_ICN900923.pdf on the CMS website.

DMEPOS Competitive Bidding: Two Important Reminders

If you intend to bid in the Round 2 Recompete and/or the national mail-order recompete of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, please carefully read the following bidding reminders:

1. **Bona Fide Bid for Each Item:** The Competitive Bidding Program regulations require each bidder to submit a bona fide bid that complies with all the terms and conditions specified in the Request for Bids (RFB) instructions. The RFB instructions define a bid as an offer to furnish an item for a particular price and time period that includes, as appropriate, any services that are directly related to the furnishing of the item. It is also important for you to consider and include your costs to purchase the item, overhead, and profit when determining a bid amount for an item— Healthcare Common Procedure Coding System (HCPCS) code.

Remember, a number of competitively bid HCPCS codes require coding verification by the Medicare Pricing, Data Analysis and Coding (PDAC) contractor. When determining a bona fide bid amount for these HCPCS codes, bidders must consider the cost for the products that have been classified by the PDAC. You may be asked to submit a rationale and documentation for these HCPCS codes to verify that you can furnish products that have been classified by the PDAC at your submitted bid amount. Product information for a HCPCS code(s) can be located by using the PDAC HCPCS code search tool.

It's also important to keep in mind the following when determining your bid amount:

- You must not submit a bid for an item at a loss in order to improve your chances of winning a contract.
- If we identify a bid as potentially non-bona fide, we will ask for documentation - such as a bill of sale, store receipt, signed written vendor quote, or invoices - and a rationale to support that bid amount.
- If a potential non-bona fide bid amount cannot be supported by some type of documentation, then the bid for that entire product category in the competitive bidding area will be disqualified.

2. **State License on File with National Supplier Clearinghouse (NSC) and in the Provider Enrollment, Chain, and Ownership System (PECOS) by March 25, 2015:** The RFB instructions also state that you must have a current copy of the applicable state license(s) on file with the NSC and in PECOS by the close of the bid window, which is March 25, 2015. Please carefully review each state's requirements for which you intend to submit a bid. You can find a guide of the states' licensing requirements and the state licensing agency contact information on the NSC website. Licensing regulations change periodically, so it's very important you know the current requirements. For example, if you plan to bid in a competitive bidding area in Colorado, you should know that a new law took effect on December 31, 2014. Go to the NSC DMEPOS State License Directory, select Colorado, review the note at the bottom of the page, and find the agency contact information. In this case, you would call the Colorado Secretary of State at 303-894-2200 for information on the law's requirements.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for "E-mail Updates" on the home page of the CBIC website. For information about the Round 2 Recompete and the national mail-order recompete, please refer to the bidder education materials located under Round 2 & National Mail-Order Recompete > Bidding Suppliers on this website. The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under the Educational Information section of the Round 2 & National Mail-Order Recompete page.

You may call the CBIC customer service center toll-free at 1-877-577-5331 from 9 a.m. to 9 p.m. prevailing Eastern Time (ET) during registration and bidding periods. For more information about licensing requirements, you may consult the appropriate license issuing agency listed on the NSC DMEPOS State License Directory or call the NSC at 866-238-9652 from 9 a.m. to 5 p.m. ET.

Holding of 2015 Date-of-Service Claims and DMEPOS Competitive Bidding Registration Reminder

Holding of 2015 Date-of-Service Claims for Services Paid Under the 2015 Medicare Physician Fee Schedule

On November 13, 2014, the CY 2015 Medicare Physician Fee Schedule (MPFS) final rule was published in the Federal Register. In order to implement corrections to technical errors discovered after publication of the MPFS rule and process claims correctly, Medicare Administrative Contractors will hold claims containing 2015 services paid under the MPFS for the first 14 calendar days of January 2015 (i.e., Thursday January 1 through Wednesday January 14). The hold should have minimal impact on provider cash flow as, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.

MPFS claims for services rendered on or before Wednesday Dec 31, 2014 are unaffected by the 2015 claims hold and will be processed and paid under normal procedures and time frames.

Registration Reminder for DMEPOS Competitive Bidding: Round 2 Recompete & National Mail-Order Recompete

CMS would like to remind all suppliers that registration is now open for those interested in participating in the Round 2 Recompete and/or the national mail-order recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In order to submit a bid(s) for the Round 2 Recompete and/or the national mail-order recompete, you must first register in the Individuals Authorized Access to CMS Computer Services (IACS) online application.

Once you have registered in IACS, you will receive a user ID and password to access the online DMEPOS Bidding System (DBidS). You must register even if you registered during a previous round of competition (Round 1 Recompete, Round 2, or the national mail-order competition). Only suppliers who have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to submit a bid.

If you are a supplier interested in bidding, you must designate one individual listed as an authorized official (AO) on your organization's CMS-855S enrollment application in the Provider Enrollment, Chain, and Ownership System (PECOS) to act as your AO for registration purposes. After an AO successfully registers, other individuals listed as an AO on the CMS-855S in PECOS may register as backup authorized officials (BAOs).The AO must approve a BAO's request to register. The AO and BAOs can designate other individuals not listed as an AO on the CMS-855S in PECOS to serve as end users (EUs).BAOs and EUs must also register for a user ID and password in IACS in order to access DBidS. The name and Social Security number of the AO and BAO entered in IACS must match exactly with what is recorded on the CMS-855S and on file in PECOS to register successfully. Bidders are prohibited from sharing user IDs and passwords.

CMS strongly urges all AOs to register no later than January 6, 2015, to ensure that BAOs and EUs have time to register. We recommend that BAOs register no later than January 20, 2015, so that they will be able to assist AOs with approving EU registration before bidding begins on January 22, 2015.

Registration extends into the bidding period and will close on Tuesday, February 17, 2015 at 9pm prevailing ET– no AOs, BAOs, or EUs can register after registration closes. Bidding will close on Wednesday, March 25, 2015.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, www.dmecompetitivebid.com, click on Round 2 & National Mail-Order Recompete, and then click on "Registration is Open" above the Registration clock. CMS strongly recommends that you:

- Review the IACS Reference Guide,
- Watch the short and very helpful instructional video, "How to Register to Submit a Bid," on your computer, tablet, or phone, and
- Use the IACS: Getting Started Registration Checklist.

CMS would also like to remind you to:

- Review and update your enrollment records. Suppliers must maintain accurate information on their CMS-855S enrollment application with the National Supplier Clearinghouse (NSC) and in PECOS. It is important to note that if your record is not current at the time of registration, you may experience delays and/or be unable to register and bid. We will also validate your bid data against your enrollment record in PECOS during bid evaluation. If it is not current or accurate, your bid(s) may be disqualified.
- Get licensed. Supplier locations must be licensed as applicable by the state in which it furnishes, or will furnish, products and services under the DMEPOS Competitive Bidding Program.
- Get accredited. Supplier locations must be accredited by a CMS-approved accrediting organization for the products and services it furnishes, or will furnish, under the DMEPOS Competitive Bidding Program.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for E-mail Updates on the home page of the CBIC website. For information about the Round 2 Recompete and the national mail-order recompete, please refer to the bidder education materials located under Round 2 & National Mail-Order Recompete > Bidding Suppliers on this website. The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under the Educational Information section of the Round 2 & National Mail-Order Recompete page.

In addition to viewing the information on the CBIC website, suppliers are encouraged to call the CBIC customer service center toll-free, at 877-577-5331, with their questions. During registration and bidding periods, the customer service center will be open from 9am to 9pm ET.

Modifiers KK, KG, KU and KW Used Under DMEPOS Competitive Bidding Program

MLN Matters® Number: MM9059
Related Change Request (CR) #: CR 9059
Related CR Release Date: February 13, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1466OTN
Implementation Date: July 6, 2015

Provider Types Affected

This MLN Matters® Article is intended for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for DMEPOS provided to Medicare beneficiaries under the competitive bidding program.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9059 to limit the use of modifiers KK, KG, KU, and KW on DMEPOS claims billed under the Competitive Bidding Program to only those uses allowed by current policy. This will reduce the number of overpayments made as a result of improper use by suppliers. Make sure your billing staffs are aware of these changes.

Background

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

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

The competitive bidding modifiers were created to identify a Healthcare Common Procedure Coding System (HCPCS) supply or accessory code that is considered both a competitive bid item and a non-competitive bid item in the same Competitive Bidding Area (CBA). Competitive bid items are identified with the appropriate modifiers in the HCPCS and pricing files available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the Internet.

When billing for beneficiaries that reside in a CBA, suppliers should only apply modifiers KG and KK to competitive bid HCPCS codes according to current policy instructions for use of these modifiers. HCPCS codes designated as valid for use with these modifiers are listed in the Single Payment Public Use Files available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home on the Internet.

Modifiers KU and KW are not currently authorized for supplier billing use and do not currently appear on the single payment file as valid for use with any DMEPOS HCPCS.

Key Point

Your DME MAC will allow claims for competitive bid items when billed with modifiers KG, KK, KU or KW only when the HCPCS/modifier combination is listed as valid on the CBIC HCPCS file. The DME MACs will return as unprocessable claims for competitive bid items when billed with modifiers KG, KK, KU or KW when the HCPCS/modifier combination is not listed as valid on the CBIC HCPCS file.

DME MACs will use the following messages when returning as unprocessable claims for competitive bid items inappropriately billed with modifiers KG, KK, KU or KW:

- Group Code CO
- CARC 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing."
- RARC MA13 – "Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code."
- RARC MA130 - "Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information."

Note: MACs will also deny adjustment claim lines containing HCPCS inappropriately billed with modifiers KG, KK, KU, or KW.

Additional Information

The official instruction for CR9059 issued to your DME MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1466OTN.pdf on the CMS website.

For more information regarding the appropriate use of Competitive Bidding modifiers, see Medicare Learning Network (MLN) article SE1035 titled: "Claims Modifiers for Use in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1035.pdf on the CMS website.

The Medicare Catalogue of Products hosts a series of DME Fact Sheets accessible at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website.

Reminder for Correct Usage of Competitive Bid Modifiers

It is imperative that suppliers bill with the correct modifiers. Noridian has made available several resources to assist. Originally posted on February 25, 2014, is the article titled: Appropriate Usage of the KK Modifier which explains when the KK modifier should be appended to claim lines. There are also two web based trainings that are available which include the presentations in PDF format. These are titled Competitive Bid and DME Modifiers. The PDF documents as well as the schedule for the upcoming training and events are available at www.noridianmedicare.com/dme/train.

For more information see:

- MLN Matters Article SE1305: https://www.noridianmedicare.com/dme/news/docs/2011/06_jun/se1035_revised.pdf
- CBIC article on Appropriate Usage of Modifiers KG, KK and KL: http://www.dmecompetitivebid.com/palmetto/cbicrd1rebid.nsf

Round 2 Competitive Bid Wheelchair Accessories Billing for Beneficiaries Not in a CBA

In Medlearn Matters 8864, Scenario 3 indicated the fee schedule amount (5%) for the wheelchair accessory would be paid. Noridian had previously reported that we would be adjusting claims that fall under this scenario. We are unable to mass adjust the claims that fall under this scenario, so suppliers will need to request a reopening on these claims.

Suppliers can call telephone reopenings to request that the claims be adjusted or submit a written reopening request.

If you have a large number of claims that fall under this scenario and you can provide a listing, please call telephone reopenings to discuss handling as a special project.

Scenario 3

- Wheelchair accessory is competitively bid in Round 2, but not Round 1
- Billed for use with any wheelchair base unit (whether competitively bid or not)
- Billed without modifier "KE" or "KY"
- Billed by a contract or non-contract supplier
- For a beneficiary that resides outside a Competitive Bid Area (CBA).

ADR Response – New Timeframe – Third Revision

MLN Matters® Number: MM8583
Revised Related Change Request (CR) #: CR 8583
Related CR Release Date: February 4, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R567PI
Implementation Date: April 6, 2015

This article was revised on February 9, 2015, to reflect the revised CR8583 issued on February 4. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 8583, which instructs MACs and Zone Program Integrity Contractors (ZPICs) to produce pre-payment review Additional Documentation Requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

Background

In certain circumstances, CMS review contractors (MACs, ZPICs, Recovery Auditors, the Comprehensive Error Rate Testing contractor and the Supplemental Medical Review Contractor) may not be able to make a determination on a claim they have chosen for review based upon the information on the claim, its attachments or the billing history found in claims processing system (if applicable) or Medicare's Common Working File (CWF).

In those instances, the CMS review contractor will solicit documentation from the provider or supplier by issuing an ADR. The requirements for additional documentation are as follows:

- The Social Security Act, Section 1833(e) - Medicare contractors are authorized to collect medical documentation. The Act states that no payment shall be made to any provider or other person for services unless they have furnished such information as may be necessary in order to determine the amounts due to such provider or other person for the period with respect to which the amounts are being paid or for any prior period.

- According to the "Medicare Program Integrity Manual," Chapter 3, Section 3.2.3.2, (Verifying Potential Errors and Tracking Corrective Actions),when requesting documentation for pre-payment review, the MAC and ZPIC shall notify providers that the requested documentation is to be submitted within 45 calendar days of the request. The reviewer should not grant extensions to the providers who need more time to comply with the request. Reviewers shall deny claims for which the requested documentation was not received by day 46.

Additional Information

The official instruction, CR 8583, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R567PI.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Completion of Certificates of Medical Necessity – Annual Reminder

Dear Physician:

We need your help! Certificates of medical necessity, commonly known as CMNs, are documents used by the Durable Medical Equipment Medical Administrative Contractors to assist in gathering information about the medical necessity of an item. When you write an order, you assume the responsibility for determining both the medical need for, and the utilization of, all healthcare services.

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

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

Printable copies of CMNs and DIFs are available on the CMS website at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html. To find the CMN/DIF you are looking for on the website, place a check next to the "Show only items containing the following word" field and enter the name of the CMN/DIF. For instance, if you are searching for the Oxygen CMN, enter the word "oxygen." Be sure that you have selected the "Show only" option and then press the "Show Items" button.

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

Sincerely,

Eileen M. Moynihan, M.D.

DIFs Usage for Enteral and Parenteral Nutrition and External Infusion Pumps

Joint DME MAC Publication

The DME MACs use DME Information Forms (DIFs) when processing claims to assure the most current information is on file and to allow the claims to pay correctly. Claims for enteral and parenteral nutrition and external infusion pumps require a DIF to be submitted with the initial claim as well as when changes in the items or quantities provided are made. DIFs are completed entirely by the supplier and do not need to be signed by the treating physician. DIFs are required to be signed and dated by the supplier.

The following table indicates the DIFs for external infusion pumps and enteral/parenteral nutrition.

DME MAC Form	CMS Form	Items Addressed
09.03	10125	External Infusion Pumps
10.03	10126	Enteral and Parenteral Nutrition

The Initial DIF: A new Initial DIF is required when:

1. An enteral formula billed with a different code, which has not been previously certified, is ordered; or,
2. For either enteral formulas or administration via pump (B9000 or B9002), there has been a break in billing of more than 60 days (plus the remaining days in the rental month) and there has been a change in the underlying medical condition that justifies coverage for the item(s).
3. A beneficiary receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump* (B9000 or B9002).

*Change in method of administration from gravity or syringe to a pump (B9000 or B9002) requires a new initial DIF for the pump and a revised DIF for the enteral nutrient (See chart below).

The Revised DIF: Required when there has been a change in any of the information recorded on the DIF. The table below lists changes that require a Revised DIF to be submitted:

Reason	Category
Changes in the drug HCPCS code	External Infusion
Change in the route of administration	External Infusion
Change in method of administration	External Infusion
Change in HCPCS code for the current nutrient provided	Nutrition
Change (increase or decrease) in the calories prescribed	Nutrition
Change in the method of administration from gravity to syringe or syringe to gravity (See above for gravity or syringe to pump)	Nutrition
Change in the number of days per week of administration	Nutrition
Change in route of administration from tube feedings to oral feedings (if billing for denial)	Nutrition

The Recertification DIF: Must be submitted when the length of need previously entered on the DIF has expired and the ordering physician is extending the length of need for the item(s).

The DIFs for External Infusion Pumps and Enteral or Parenteral Nutrition can be located on each DME MAC website.

For additional information, refer to the Supplier Manual, the applicable Local Coverage Determination, and related Policy Article.

Modifier Requirements Due To Lack of Physician's Order (Modifier EY)

Jurisdiction D, Noridian Healthcare Solutions, has recently received inquiries regarding the proper submission of modifiers EY, GY and GA when a denial is anticipated due to the lack of a prescription. To reduce errors related to this process, it is important to remember that all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items require a prescription (physician's order). Some DMEPOS items require a detailed written order prior to dispensing (WOPD), while others require a detailed written order (DWO) prior to billing. The specific requirements for an order are specified in the Medical Policy (Local Coverage Determination (LCD) and/or Policy Article) for the specific item.

Please remember that if you submit a claim to Medicare and specified requirements for an order are not met, you must append modifier EY ("No physician or other licensed health care provider order for this item or service") to the claim line. This informs the Durable Medical Equipment, Medicare Administrative Contractor (DMEMAC) that you do not have a physician's order for the item. Additionally, items submitted with the EY modifier must be on a separate claim from those items not requiring an EY modifier.

When lack of an order is expected to result in a medical necessity denial (ANSI 50 –"These are non-covered services because this is not deemed a 'medical necessity' by the payer"), you must execute an Advance Beneficiary Notice of Noncoverage (ABN) if you intend to protect your company from financial liability. If you have properly executed an ABN, you must append modifier GA ("Waiver of liability statement issued as required by payer policy, individual case") to the claim line in addition to modifier EY.

However, when the lack of a physician's order is expected to result in a statutory denial, an ABN is not required. If you correctly submit the claim with modifier EY appended to the claim line, the claim will process and deny with ANSI 96 ("Non-covered charge(s)"). Neither modifier GY ("Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit") nor modifier GA is required when an item is expected to deny on the basis of a statutory denial (ANSI 96).

As a reminder, all items specified in MLN Matters 8304 which are subject to the Affordable Care Act 6407 require a WOPD. This is a statutory requirement. You 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. If you deliver the item prior to your receipt of a written order, it will be denied as statutorily noncovered. Therefore, when you do not have an order for these items, you must submit the claim with modifier EY. Again, neither modifier GY nor GA would be required.

We encourage you to refer to the LCD and related Policy Article for specific order and other documentation requirements for the items you provide.

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

Proof of Delivery Reminder

Joint DME MAC Article

Recently during claims review it was noted that suppliers have a misunderstanding about the purpose of proof of delivery (POD). All items of durable medical equipment, prosthetics, orthotics and supplies require POD. Proof of delivery serves multiple purposes, the most obvious being confirmation that the beneficiary received the item for which Medicare was billed. In addition to confirming receipt of an item, POD also serves other functions in Medical Review, specifically the ability of contractor's review staff to determine correct coding. As noted in the Documentation Section of the DME MAC local coverage determinations (LCDs):

> 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.

To enable review staff to make a correct coding determination, there must be sufficient details about the item delivered to ascertain whether or not the item(s) on the detailed written order are the same item(s) included on the claim and coded with the correct HCPCS code. To accomplish this task, the POD must contain specific information about the products to make this determination. As noted in the DME MAC LCD Documentation Section for each of the three methods of delivery, one of the requirements for proper POD documentation is:

DOCUMENTATION

Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)

Reviewers often see a reiteration of the HCPCS code narrative on the POD form as the detailed description of the item, particularly for orthotics and prosthetics. This is NOT adequate for POD purposes. Simply restating the HCPCS code narrative description does not allow review staff to determine what specific item(s) is being billed and if it is coded correctly. The preferred method is use of a brand name and model number, brand name and serial number or manufacturer name and part number to identify the product. If this type of information is not available for the product, suppliers may use a detailed narrative description of the item; however, it must contain sufficient descriptive information to allow a proper coding determination. This "narrative description" of the item is not the HCPCS code narrative.

Proof of delivery documents that fail to properly identify DMEPOS products and allow reviewers to make a correct coding determination will be denied for insufficient delivery information.

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

DRUGS AND BIOLOGICALS

Coverage and Coding – New Oral Antiemetic Drug Akynzeo®

Joint DME MAC Publication

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

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

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

Claims for Akynzeo® must be billed using NOC code Q0181, and must be billed on the same claim with dexamethasone (J8540) to qualify for consideration of coverage and there must be no unbundling of the netupitant and palonosetron combination in Akynzeo®.

If Akynzeo® (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. Further instructions in that policy include but are not limited to the following items.

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 (V58.11).

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

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

Please refer to the DME Oral Anti-emetic Drug (Replacement for Intravenous Antiemetics) Local Coverage Determination for further information.

Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code J7507, J7517, J7518 and J7520. The quarterly edit effectiveness results from June 2014 through September 2014 are as follows:

The J7507 review involved 3,069 claims, of which 2,643 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 67%.

The J7517 review involved 2,123 claims, of which 1,537 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 67%.

The J7518 review involved 1,677 claims, of which 1,146 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 65%.

The J7520 review involved 486 claims, of which 353 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 70%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- No refill request was submitted
- No proof of delivery (POD) was submitted
- POD submitted was invalid
- Detailed written order (DWO) was incomplete or missing elements
- No DWO was submitted

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Immunosuppressive Drugs Local Coverage Determination (LCD) L68 and Policy Article A25366.

Suppliers can also review a specific policy Documentation Checklist for Immunosuppressive Drugs on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation was received in response to ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

No refill request was submitted.

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.

The POD submitted was either invalid or no POD was submitted for review.

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 durable medical equipment 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.

Suppliers are required to maintain POD documentation in their files. There are three methods of delivery:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- 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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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 record 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.

The DWO submitted was either incomplete/missing elements or no DWO was submitted.

The supplier for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is required to keep on file a physician prescription (order). A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary. The treating physician must sign and date the detailed written order.

A 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 and the start date, if start date is different from the 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).

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.

ASP Medicare Part B Drug Pricing Files and Revisions – April 2015 Update

MLN Matters® Number: MM9084
Related Change Request (CR) #: CR 9084
Related CR Release Date: January 30, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3180CP
Implementation Date: April 6, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9084 informs Medicare MACs to download and implement the April 2015 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 2014, ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis.

The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "Medicare Claims Processing Manual" (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 50 (Outpatient PRICER); see http://www.cms.gov/manuals/downloads/clm104c04.pdf on the CMS website.)

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

Files	Effective Dates of Service
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
October 2014 ASP and ASP NOC	October 1, 2014, through December 31, 2014
July 2014 ASP and ASP NOC	July 1, 2014, through September 30, 2014
April 2014 ASP and ASP NOC	April 1, 2014, through June 30, 2014

The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local MAC processing the claim shall make these determinations.

Additional Information

The official instruction, CR 9084 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3180CP.pdf on the CMS website.

Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code J7507, J7517, J7518 and J7520. The quarterly edit effectiveness results from September 2014 through December 2014 are as follows:

The J7507 review involved 3,398 claims, of which 2,518 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 72%.

The J7517 review involved 1,971 claims, of which 1,456 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 71%.

The J7518 review involved 1,482 claims, of which 1,042 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 68%.

The J7520 review involved 453 claims, of which 335 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 72%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- No refill request was submitted
- No proof of delivery (POD) was submitted
- POD submitted was invalid
- Detailed written order (DWO) was incomplete or missing elements

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Immunosuppressive Drugs (LCD) L68 and Policy Article A25366.

Suppliers can also review a specific policy Documentation Checklist for Immunosuppressive Drugs on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation was received in response to ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

No refill request was submitted.

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.

The POD submitted was either invalid or no POD was submitted for review.

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 durable medical equipment 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.

Suppliers are required to maintain POD documentation in their files. 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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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 record 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.

The DWO submitted was either incomplete/missing elements or no DWO was submitted.

The supplier for all durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) is required to keep on file a physician prescription (order). A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary. The treating physician must sign and date the detailed written order.

A 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 and the start date, if start date is different from the 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).

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.

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

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.

Viewing Presentation

To view these presentations, go to the Education Tools page under Training and Events. All DME on Demand presentations will be listed under the Presentations column.

CEDI

- What is CEDI?
- Who is CEDI?
- CEDI Helpdesk CAN assist with
- CEDI Helpdesk CANNOT assist with
- Resources

External Breast Prosthesis: Coverage Criteria, Refills and Replacements

Coverage Criteria

- L8015
- L8000-L8002
- L8020 and L8030
- L8035
- L8010 and A4280
- Supplies and Accessories
- Refill Requirements
- Replacement
- Resources

External Breast Prosthesis: Modifiers, Upgrades and Documentation

- Modifiers
- Upgrades
- Documentation
- Continued Use
- Continued Medical Need
- Resources

Eye Prosthesis

- Coverage Criteria
- Polishing/Resurfacing
- Enlargement/Reduction
- Modifiers
- Trial Scleral Shells
- Replacement
- Resources

Facial Prosthesis

- Where Should Claims be Submitted?
- Coverage
- Covered Supplies
- Modifications
- Repairs
- Replacement
- Codes for Modifications/Repairs
- Documentation
- Modifiers
- When to use Modifiers
- Resources

Gradient Compression Stockings: Coding

- AW Modifier
- RT and LT Modifiers
- Resources

Gradient Compression Stockings: Coverage Criteria

- Coverage Criteria
- Quantities
- Resources

Hospital Beds: Billing Reminders

- Billing Reminders
- E1399
- Noncovered Items
- ACA – Section 6407
- Bundling
- Support Surface Reminders
- Modifiers
- Resources

Hospital Beds: Coding and Coverage

- Coding and Coverage
- Trapeze Equipment
- Heavy Duty Trapeze Equipment
- Bed Cradles
- Side Rails or Safety Enclosures
- Mattresses
- Resources

Hospital Beds: Coding

- Coding

- Fixed Height
- Variable Height
- Semi-Electric
- Heavy Duty Extra Wide
- Extra Heavy Duty
- Total Electric
- Resources

Hospital Beds: Coverage Criteria

- Coverage
- Fixed Height Coverage Criteria
- Variable Height Coverage
- Variable Height Feature
- Semi-Electric Coverage
- Heavy Duty Extra Wide Coverage
- Extra Heavy Duty HCPCS
- Total Electric
- Resources

Hospital Beds: Upgrades

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

LLP: Physician and Prosthetist Records

- Physician Records
- Physician and Prosthetist Records
- Prosthetist Records
- Resources

Other Medicare Contractors

- CERT
- CEDI
- CBIC
- NSC
- QIC
- Recovery Auditor
- PDAC
- Resources

Oxygen: CMN Requirements

- Initial CMN
- Recertification

- Revised CMN
- Other CMN Notes
- Resources

Oxygen: Coding and Billing Guidelines

- Modifiers
- Months 1-36
- Break in Service
- Months 37-60
- Contents
- Contents Billing Chart
- Maintenance and Service
- Reasonable Useful Lifetime
- Replacement
- Relocation and Travel
- Resources

Oxygen: Coverage Guidelines

- Covered Home Oxygen Therapy
- Home Oxygen-Not Reasonable and Necessary
- Coverage Groups
- Group I
- Group II
- Resources

Oxygen: Testing Requirements

- Blood Gas Study
- Testing
- Sleep Oximetry Studies
- Overnight Oximetry, OSA and PSG
- Inpatient vs. Outpatient Testing
- Resources

PRSS – Group 1: Billing Reminders

- A4640 or E0182
- Bundling
- PDAC
- ABN
- KX, GA and GZ Modifiers

PRSS – Group 1: Coding

- E0185
- E0197
- E0198

- E0199
- E0184
- E0186, E0187 and E0196
- E0181, E0182 and A4640
- A9270 and E1399
- E0181, E0182 and A4640

PRSS – Group 1: Coverage Criteria

- Coverage Criteria 1
- Coverage Criteria 2
- Coverage Criteria 3
- Additional Coverage Information

PRSS – Group 2: Billing Reminders

- Billing Reminders
- Continued Use for Group 2 PRSS
- KX Modifier
- GA and GZ Modifiers
- KX, GA and GZ Modifiers

PRSS – Group 2: Coding

- Coding
- E0193
- E0277
- E0371
- E0372
- E0373
- E1399
- Coding Guidance

PRSS – Group 2: Coverage Criteria

- Coverage Criteria Group A
- Coverage Criteria Group B
- Coverage Criteria Group C

PRSS: Ulcer Stages

- Normal Skin
- Stage I Ulcer
- Stage II Ulcer
- Stage III Ulcer
- Stage IV Ulcer
- Unstageable Ulcer
- Ulcer Treatment Program

Spinal Orthosis: Coverage Criteria
- Braces Benefit Category
- Types of Orthoses
- Orthosis Coverage
- Covered and Noncovered Flexible Spinal Support Garments
- Resources

Surgical Dressings: Coverage Criteria
- Coverage Criteria
- Debridement
- Resources

Surgical Dressings: Orders
- Preliminary/Dispensing Order
- DWO Required Elements
- DWO: Additional Elements
- When a new order is required
- Resources

Surgical Dressings: Refill Requirements
- Refill Requirements
- Required Refill Elements
- Reminders
- Resources

The Structure of Medicare
- CMS
- Social Security Act
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- Resources

Therapeutic Shoes for Persons with Diabetes: Documentation Requirements
- Documentation Overview
- Authorized to Order
- New Order Requirements
- Certifying Physician
- Certifying Physician Statement
- Recommended Form
- Certifying Physician- Criterion 2
- Supplier In-Person Evaluation Documentation
- Resources

Walkers: Billing Reminders
- Gait Trainer
- Replacements/Accessories/Coding

EDUCATIONAL

- Heavy Duty Walker
- Claim Requirements
- Bundling
- Resources

Walkers: Coding

- Wheeled Walkers
- Heavy Duty Walker
- Resources

Walkers: Coverage Criteria

- Mobility Limitation
- Standard Walker
- Walker with Enclosed Frame
- Heavy Duty Walker
- Walker with Trunk Support
- Leg Extensions
- Resources

ENDEAVOR

Eandeavor Last Paid Supply Orthotic Prosthetic Vision Date of Service

DME suppliers are now able to view the last paid date of service for supply, orthotic, prosthetic, and vision HCPCS codes (A, L, V). This information is offered through the Same or Similar inquiry.

To view this information, enter the beneficiary Medicare number, first and last name, and date of birth. Under Search Options, check the box next to Option 2 and enter the HCPCS code. If the inquired on HCPCS code is found in the beneficiary history, Endeavor displays the date of service, number of units, the supplier's name and phone number of the most recent paid date of service.

If both checkboxes next to the Options are selected, the fields will not be fillable. Uncheck one box in order to inquire.

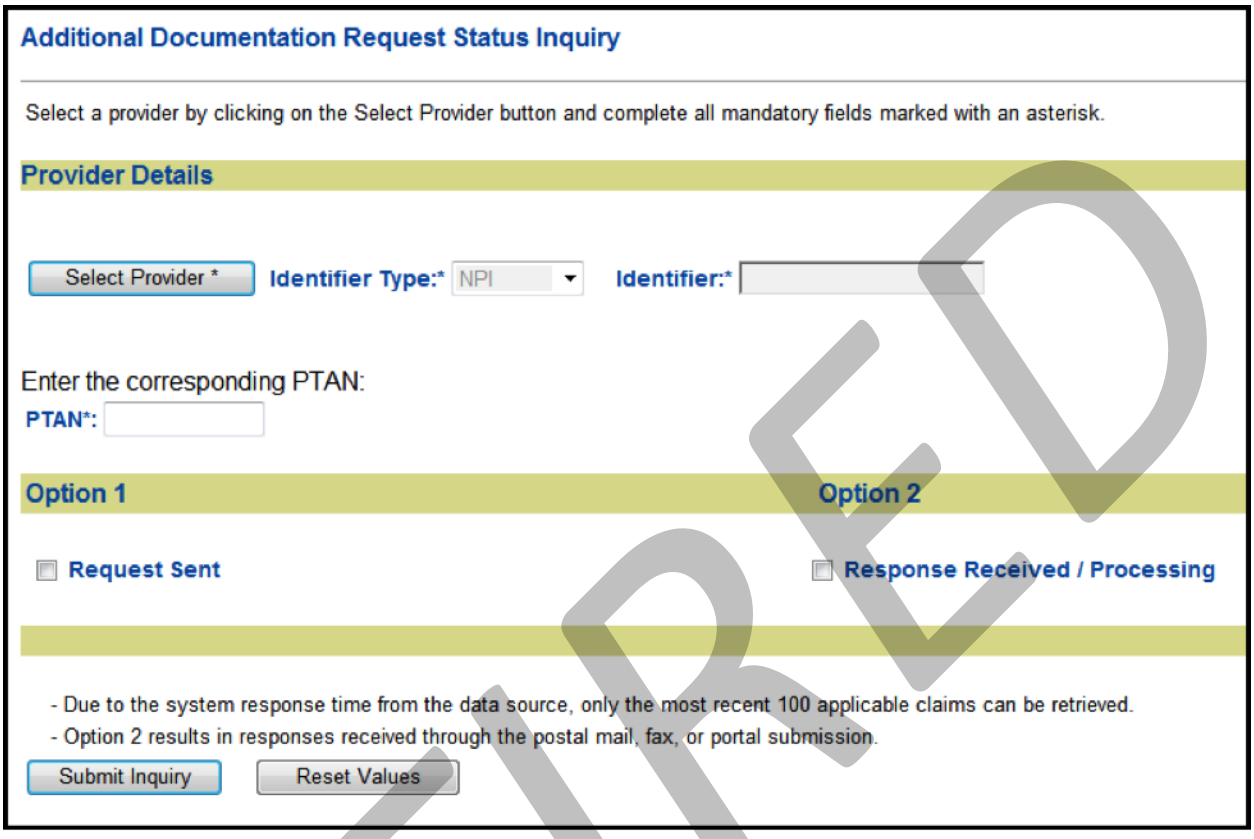
The Same or Similar option has no changes to the functionality. Only those HCPCS codes listed on the Same or Similar Reference Chart are tracked and can be inquired on.

Endeavor Now Offers Additional Documentation Request Status Inquiry and Submission

Effective January 30, 2015, Noridian's Endeavor online portal now offers suppliers the option to inquire on the status of Additional Documentation Request (ADR) submissions and provides suppliers the ability to upload documentation to support the ADR. The different ways suppliers can view/upload documents that support ADR requests are detailed below.

Additional Documentation Request Status Inquiry

Select "ADR Inquiry" from either the left-hand navigation or the center of the Main Menu.



Obtain ADR Status

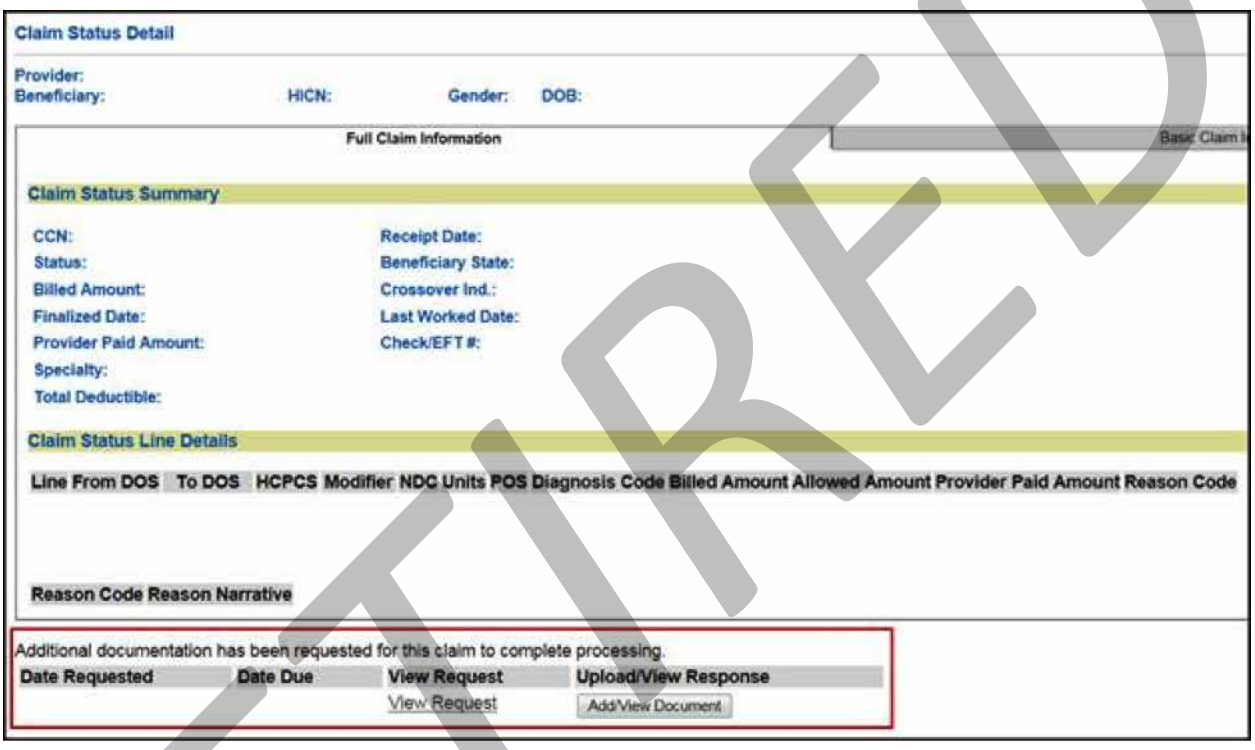
- Select applicable National Provider Identifier (NPI) using "Select Provider" button
- Enter corresponding Provider Transaction Access Number (PTAN)
- Choose one of the below. Each option will provide different results
  - **"Request Sent" under Option 1** to view up to 100 claims for that NPI and PTAN combination in which Noridian mailed an ADR letter to supplier but response has not yet been received. This option will return claim number, Health Insurance Claim Number (HICN), beneficiary's first and last name, date of service, date ADR was requested and date response is due to Noridian. Suppliers also have ability to view a portal-friendly version of letter that was mailed and can also upload supporting documentation
  - **"Response Received/Processing" under Option 2** to view up to 100 claims that have had an ADR letter issued by Noridian and supplier has responded in a timely manner and is pending processing. This option returns claim number along with HICN. To view documents that have been submitted for a specific claim, select Claim Number

Note: There will be a delay from the date a supplier responds via postal mail, Electronic Submission of Medical Documentation (esMD), fax and the portal to the day the claim may display in the ADR Response Received/Processing status.

Claim Status Detail Update

To help suppliers see claims impacted by the ADR process, the Claim Status Inquiry results have also been updated. After performing a Claim Status Inquiry, suppliers can choose the Claim Control Number (CCN) that has had an ADR letter issued by Noridian.

- From Claim Status Detail results, suppliers can view the date the ADR was requested and the date due to Noridian
- The mailed ADR letter can be viewed and/or documents mailed, faxed or submitted through portal can be reviewed
- Suppliers may upload supporting documentation from this inquiry



Direct all questions regarding ADR letters or the types of documentation needed to support an ADR to the Supplier Contact Center.

Incorporation of Provider Enrollment Policies in CMS-4159-F into Pub. 100-08, PIM, Chapter 15

MLN Matters® Number: MM8901
Related Change Request (CR) #: CR 8901
Related CR Release Date: December 12, 2014
Effective Date: March 18, 2015
Related CR Transmittal #: R561PI
Implementation Date: March 18, 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians and eligible professionals who prescribe Medicare Part D drugs, and for providers and suppliers that submit claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8901 incorporates into Chapter 15 of the "Program Integrity Manual" (PIM) several provider enrollment policies in the final rule titled, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs."

Key Points of CR8901

The key points of the updated Chapter 15 of the "Medicare Program Integrity Manual" are as follows:

- If a MAC approves a provider's or supplier's Form CMS-855 reactivation application or Reactivation Certification Package (RCP) for a Part B non-certified supplier, the reactivation effective date will be the date the MAC received the application or RCP that was processed to completion. Also, upon reactivating billing privileges for a Part B non-certified supplier, the MAC will issue a new Provider Transaction Access Number (PTAN).
- CMS may deny a physician's or eligible professional's Form CMS-855 enrollment application under § 424.530(a)(11) if:
  - The physician's or eligible professional's Drug Enforcement Administration (DEA) Certificate of Registration to dispense a controlled substance is currently suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs, and such suspension or revocation is in effect on the date the physician or eligible professional submits his or her enrollment application to the Medicare contractor.
- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(13) if:
  - The physician's or eligible professional's DEA Certificate of Registration is suspended or revoked; or
  - The applicable licensing or administrative body for any state in which the physician or eligible professional practices has suspended or revoked the physician's or eligible professional's ability to prescribe drugs.
- CMS may revoke a physician's or eligible professional's Medicare enrollment under § 424.535(a)(14) if CMS determines that the physician or eligible professional has a pattern or practice of prescribing Part D drugs that falls into one of the following categories:
  - The pattern or practice is abusive or represents a threat to the health and safety of Medicare beneficiaries or both.
  - The pattern or practice of prescribing fails to meet Medicare requirements.

Additional Information

The official instruction, CR8901, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R561PI.pdf on the CMS website.

ENROLLMENT

Revised CMS 855R Application - Reassignment of Medicare Benefits

MLN Matters® Number: SE1432

Provider Types Affected

This MLN Matters® Special Edition (SE) is intended for physicians, non-physician practitioners, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) and who choose to reassign their benefits or accept reassigned benefits of those claims.

Provider Action Needed

Physicians, non-physician practitioners, providers, and suppliers must use the revised Centers for Medicare & Medicaid Services (CMS) 855R (Reassignment of Benefits) application beginning June 1, 2015.

The revised CMS 855R application will be available for use on the CMS.gov website as of December 29, 2014. MACs may accept both the current and revised versions of the CMS 855R through May 31, 2015, after which the revised CMS 855R application will be required to be submitted.

After May 31, 2015, MACs will return any newly submitted CMS 855R applications on the previous version (07/11) to the provider/supplier with a letter explaining that the CMS 855R has been updated and the current version of the CMS 855R (11/12) must be submitted.

Make sure that your billing staffs are aware of these changes.

Background

Physicians, non-physician practitioners, providers, and suppliers must use the revised CMS 855R application starting June 1, 2015. The revised CMS 855R has been streamlined and some sections have been re-ordered for clarity. The revised form includes an optional section for primary practice location address. This information is shared with other programs such as Physician Compare to help beneficiaries identify where their physicians are primarily practicing. This address must be one that is affiliated with the individual/organization where the benefits are being reassigned.

Additional Information

Visit the Medicare Provider Supplier Enrollment webpage for more information about Medicare enrollment, available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the CMS website.

ENTERNAL AND PARENTERAL NUTRITION

Enteral Nutrition (HCPCS B4150, B4154) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes B4150 and B4154. The quarterly edit effectiveness results from June 2014 through September 2014 are as follows:

The B4150 review involved 738 claims, of which 496 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 67%.

The B4154 review involved 1,114 claims, of which 712 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 59%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Detailed written order (DWO) was incomplete or missing required elements
- DWO was signed and dated by physician after the date of service with no dispensing order submitted
- Refill request was incomplete or missing elements
- Coverage criteria were not met

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Enteral Nutrition Local Coverage Determination (LCD) L11568 and Policy Article A25361.

Suppliers can also review a specific policy Documentation Checklist for Enteral Nutrition on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation received in response to ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

DWO was incomplete or missing required elements.

A 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 and the start date, if start date is different from the 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

DWO was signed and dated by physician after the date of service with no dispensing order submitted.

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 and the start date, if the start date is different from the 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).

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.

Refill request was incomplete or missing elements.

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., Positive Airway Pressure (PAP) and Respiratory Assist Device (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.

Coverage criteria were not met

Enteral nutrition is covered for a beneficiary who has (a) permanent non-function or disease of the structures that normally permit food to reach the small bowel or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the beneficiary's overall health status.

E0776 (IV Pole) Billed with Enteral or Parenteral Nutrition

When billing claims with HCPCS E0776 (IV Pole) for Enteral and Parenteral Nutrition, the BA modifier must be appended to E0776. E0776 can be used for Enteral Nutrition, Parenteral Nutrition, as well as External Infusion Pumps. The BA modifier indicates that the IV pole is being used in conjunction with Enteral or Parenteral Nutrition. Claims for E0776 that do not contain the BA modifier that are billed with Enteral or Parenteral Nutrition codes will be denied as unprocessable, with the following remittance messages.

This claim must be corrected and resubmitted.

- Claim Adjustment Reason Code (CARC) 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.

Remittance Advice Remark Code (RARC) N519: Invalid combination of HCPCS modifiers.

Enteral Nutrition (HCPCS B4150, B4154) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS codes B4150 and B4154. The quarterly edit effectiveness results from September 2014 through December 2014 are as follows:

The B4150 review involved 621 claims, of which 407 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 63%.

The B4154 review involved 419 claims, of which 220 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 47%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Detailed written order (DWO) was incomplete or missing required elements
- DWO was signed and dated by physician after the date of service with no dispensing order submitted
- Coverage criteria was not met

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Enteral Nutrition (LCD) L11568 and Policy Article A25361.

Suppliers can also review a specific policy Documentation Checklist for Enteral Nutrition on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation received in response to ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

DWO was incomplete or missing required elements.

A 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 and the start date, if start date is different from the 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

DWO was signed and dated by physician after the date of service with no dispensing order submitted.

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 and the start date, if the start date is different from the 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).

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.

Coverage criteria was not met.

Enteral nutrition is covered for a beneficiary who has (a) permanent non-function or disease of the structures that normally permit food to reach the small bowel or (b) disease of the small bowel which impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the beneficiary's overall health status.

The beneficiary must have a permanent impairment. Permanence does not require a determination that there is no possibility that the beneficiary's condition may improve sometime in the future. If the judgment of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. Enteral nutrition will be denied as non-covered in situations involving temporary impairments.

Coverage and Correct Coding of BlincytoTM

Joint DME MAC Publication

On December 03, 2014, the FDA gave accelerated approval for Blinatumomab (BlincytoTM) for the treatment of Philadelphia negative relapsed/refractory acute lymphoblastic leukemia. BlincytoTM is a bispecific CD19-directed CD3 T-cell engager that activates endogenous T cells when bound to the CD19-expressing target cell (B cells). Activation of the immune system results in release of inflammatory cytokines. The FDA-approved schedule is for 6-week cycles, for a total 5 cycles.

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

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

Claims for BlincytoTM for dates of service on or after December 03, 2014, must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information:

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

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

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

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

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

Joint DME MAC Publication

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

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

Claims for Duopa® for dates of service on or after January 09, 2015 must be submitted using the HCPCS code J7799 (NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME). Suppliers are reminded that when submitting claims for items coded J7799, the supplier must include the following information on each claim:

- Name of Drug
- Dosage Strength

- Amount Dispensed (e.g., total mg)
- Administration Instructions

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

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

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

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

External Infusion Pumps (HCPCS E0781) Results of Service Specific Prepayment Probe Review

The Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS code E0781. This review was initiated based on the Comprehensive Error Rate Testing (CERT) Review Analysis.

The E0781 review involved 106 claims, of which 100 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 90%.

Capped Rental Items

As of January 1, 2006: Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.

Modifiers used in this category are as follows:

- RR Rental
- KH First rental month
- KI Second and third rental months
- KJ Fourth to the thirteenth months

Payment for items in which the first rental month occurred on/after January 1, 2006, may not exceed a period of continuous use longer than 13 months. After 13 months of rental have been paid, the beneficiary owns the DME item, and after that time Medicare pays for reasonable and necessary maintenance and servicing of the item, i.e., parts and labor not covered by a supplier's or manufacturer's warranty.

When there is a break in billing for the equipment during the rental period, such as the beneficiary entering a SNF or hospital, if that interruption continues beyond the end of the rental month in which use ceases, no additional payment will be made until the use of the item resumes. A new date of service will be established when use resumes. Unreimbursed months of interruption will not apply toward the 13-month limit.

A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days, plus the days remaining in the rental month in which the use ceases (not calendar month, but the 30-day rental period) in order for a new 13-month rental to begin. In these situations, suppliers must obtain from the ordering physician a new prescription, a new Certificate of Medical Necessity (CMN) and a statement describing the reasons for the interruption. If this information is not submitted, a new 13-month period does not begin. Please be thorough, as the documentation will be carefully reviewed.

Top Denial Reasons

- The DME Information Form (DIF) submitted was incomplete or invalid.
- The proof of delivery (POD) was invalid or not submitted.
- The date of signature on the order was after the date of service with no verbal or dispensing order submitted.

Going Forward

Noridian will close this probe review on HCPCS code E0781.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the External Infusion Pumps Local Coverage Determination (LCD) L11570 and Policy Article A19834.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Suppliers can also review a specific policy Documentation Checklist for External Infusion Pumps on the Noridian website

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The DIF submitted was incomplete or invalid.

Policy Specific Documentation Requirements

A DIF which has been completed, signed, and dated by the supplier, must be kept on file by the supplier and made available upon request. The DIF for External Infusion Pumps is CMS Form 10125. The initial claim must include an electronic copy of the DIF.

If a beneficiary begins using an infusion for one drug and subsequently the drug is changed another drug is added or if the code for a current drug changes, a Revised DIF must be submitted for use of the pump. The additional new or changed drug or the new HCPCS code for the existing drug must be listed along with all other drugs for which the pump is used should be included on the Revised DIF.

The proof of delivery (POD) was invalid or not submitted.

Proof of Delivery (PIM 4.26, 5.8)

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 Office of Inspector General (OIG) for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. For external infusion pumps and supplies used with these pumps there are two methods of delivery:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service

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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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 record must contain the information specified above.

The date of signature on the order was after the date of service with no verbal or dispensing order submitted.

Perscription (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 and the start date, if the start date is different from the 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).

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.

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 and the start date, if start date is different from the 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).

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.

External Infusion Pumps (HCPCS E0784) Results of Service Specific Prepayment Probe Review

The Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes E0784. This review was initiated based on the Comprehensive Error Rate Testing (CERT) Review Analysis.

The E0784 review involved 108 claims, of which 96 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 88%.

Capped Rental Items

As of January 1, 2006: Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.

Modifiers used in this category are as follows:

- RR Rental
- KH First rental month
- KI Second and third rental months
- KJ Fourth to the thirteenth months

Payment for items in which the first rental month occurred on/after January 1, 2006, may not exceed a period of continuous use longer than 13 months. After 13 months of rental have been paid, the beneficiary owns the DME item, and after that time Medicare pays for reasonable and necessary maintenance and servicing of the item, i.e., parts and labor not covered by a supplier's or manufacturer's warranty.

When there is a break in billing for the equipment during the rental period, such as the beneficiary entering a skilled nursing facility (SNF) or hospital, if that interruption continues beyond the end of the rental month in which use ceases, no additional payment will be made until the use of the item resumes. A new date of service will be established when use resumes. Unreimbursed months of interruption will not apply toward the 13-month limit.

A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions must exceed 60 consecutive days, plus the days remaining in the rental month in which the use ceases (not calendar month, but the 30-day rental period) in order for a new 13-month rental to begin. In these situations, suppliers must obtain from the ordering physician a new prescription, a new Certificate of Medical Necessity (CMN) and a statement describing the reasons for the interruption. If this information is not submitted, a new 13-month period does not begin. Please be thorough, as the documentation will be carefully reviewed.

Top Denial Reasons

- No medical records submitted to indicate the beneficiary has been evaluated at least every three months.
- The documentation submitted did not support criterion C or criterion D.
- The documentation submitted did not contain a valid date stamp or similar.
- The documentation submitted did not contain office notes or medical records.

Going Forward

Noridian will close this probe review on HCPCS codes E0784.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the External Infusion Pumps Local Coverage Determination (LCD) L11570 and Policy Article A19834.

Suppliers can also review a specific policy Documentation Checklist for External Infusion Pumps on the Noridian website

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No medical records submitted to indicate the beneficiary has been evaluated at least every three months.

Continued coverage of an external insulin pump and supplies requires that the beneficiary be seen and evaluated by the treating physician at least every 3 months. In addition, the external insulin infusion pump must be ordered and follow-up care rendered by a physician who manages multiple beneficiaries on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy.

The documentation submitted did not support criterion C or criterion D.

Coverage Criteria

Administration of continuous subcutaneous insulin for the treatment of diabetes mellitus (See Diagnosis Codes that Support Medical Necessity section below) if criterion A or B is met and if criterion C or D is met:

- C-peptide testing requirement – must meet criterion 1 or 2 and criterion 3:
  - C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method.
  - For beneficiaries with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 per cent of the lower limit of normal of the laboratory's measurement method.
  - A fasting blood sugar obtained at the same time as the C-peptide level is less than or equal to 225 mg/dl.
- Beta cell autoantibody test is positive.
- The beneficiary has completed a comprehensive diabetes education program, has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria (1 - 5) while on the multiple injection regimen:
  - Glycosylated hemoglobin level (HbA1C) greater than 7 percent
  - History of recurring hypoglycemia
  - Wide fluctuations in blood glucose before mealtime
  - Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL
  - History of severe glycemic excursions
- The beneficiary has been on an external insulin infusion pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.

If criterion A or B is not met, the pump and related accessories, supplies, and insulin will be denied as not reasonable and necessary. If criterion C or D is not met, the pump and related accessories, supplies, and insulin will be denied as not reasonable and necessary.

Continued coverage of an external insulin pump and supplies requires that the beneficiary be seen and evaluated by the treating physician at least every 3 months. In addition, the external insulin infusion pump must be ordered and follow-up care rendered by a physician who manages multiple beneficiaries on continuous subcutaneous insulin infusion therapy and who works closely with a team including nurses, diabetic educators, and dieticians who are knowledgeable in the use of continuous subcutaneous insulin infusion therapy.

Subcutaneous insulin is administered using ambulatory infusion pump E0784. Claims for usage of infusion pumps other than E0784 will be denied as not reasonable and necessary.

The documentation submitted did not contain a valid date stamp or similar.

Written Order Prior to Delivery Requirements

WOPD Needed for Codes in CR8304

A detailed written order prior to delivery (WOPD) is required for External Infusion Pumps (HCPCS E0784). 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.

For an item addressed in this policy 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 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.

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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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 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 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 Affordable Care Act (ACA) order requirements are met.

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.

The documentation submitted did not contain office notes or medical records.

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.

General (PIM 5.7–5.9)

The Indications and Limitations of Coverage and/or Medical Necessity section of this LCD contain numerous reasonable and necessary (R&N) requirements. The Nonmedical 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.

Blood Glucose Test or Reagent Strips (HCPCS A4253) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code A4253. The quarterly edit effectiveness results from July 2014 through September 2014 are as follows:

The A4253 review involved 3781 claims, of which 3687 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 92%.

Top Denial Reasons

- No physician's medical office records were received.
- Documentation submitted did not support the specific reason for the additional supplies.
- Documentation submitted did not support the actual testing frequency that corroborates with the quantity of supplies that have been dispensed.
- No documentation was received in response to the Additional Documentation Request (ADR) letters.

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Glucose Monitors Local Coverage Determination (LCD) L196 and Policy Article A33673.

Suppliers can also review a specific policy Documentation Checklist for Glucose Monitors and Supplies on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No physician's medical office records were received.

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.

General (PIM 5.7–5.9)

The Nonmedical 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 (CMNs), 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.

Documentation submitted did not support the specific reason for the additional supplies.

For services performed on or after 11/01/12 – (Criterion B for high utilization) - The treating physician has seen the beneficiary, evaluated their diabetes control within six months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary.

Documentation submitted did not support the actual testing frequency that corroborates with the quantity of supplies that have been dispensed.

For services performed on or after 11/01/12 – (Criterion C for high utilization) - If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

No documentation was received in response to the ADR letters.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

Blood Glucoses Test or Reagent Strips (HCPCS A4253) Quarterly Results of Documentation Compliance Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code A4253. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from September 1 through November 30, 2014, resulted in an overall error rate of 63%.

Top Denial Reasons

- The requested documentation was not received by the contractor within the allotted timeframe.
- Documentation to support frequency of testing was not provided
- No proof of delivery (POD) was received.
- The refill requirements were not met.

Going Forward

Based on the results of this review, Noridian will continue with the Documentation Compliance Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Glucose Monitors Local Coverage Determination (LCD) L196 and Policy Article A33673.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The requested documentation was not received by the contractor within the allotted timeframe.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

Missing testing logs or documentation indicating frequency of testing.

The quantity of test strips (A4253) and lancets (A4259) that are covered depends on the usual medical needs of the beneficiary and whether or not the beneficiary is being treated with insulin, regardless of their diagnostic classification as having Type 1 or Type 2 diabetes mellitus. Coverage of testing supplies is based on the following guidelines:

High Utilization

For a beneficiary who is not currently being treated with insulin injections, more than 100 test strips and more than 100 lancets every 3 months are covered if criteria (a) – (c) below are met.

For a beneficiary who is currently being treated with insulin injections, more than 300 test strips and more than 300 lancets every 3 months are covered if criteria (a) – (c) below are met.

1. Basic coverage criteria for all home glucose monitors and related accessories and supplies are met; and,
2. The treating physician has seen the beneficiary, evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines and has documented in the beneficiary's medical record the specific reason for the additional materials for that particular beneficiary; and,
3. If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the beneficiary is actually testing or a copy of the beneficiary's log) that the beneficiary is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the beneficiary is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

If neither basic coverage criterion (1) or (2) is met, all testing supplies will be denied as not reasonable and necessary. If quantities of test strips or lancets that exceed the utilization guidelines are provided and criteria (a) – (c) are not met, the amount in excess will be denied as not reasonable and necessary.

No POD was received.

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.

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.

Suppliers are required to maintain POD documentation in their files. 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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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 record 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.

The refill requirements were not met.

For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products (A4233–A4236, A4253, A4256, A4258 and A4259) 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. 100-8, 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 three (3)-month quantity at a time.

HOSPITAL BEDS

Hospital Bed (HCPCS E0250) Notification of Service Specific Prepayment Probe Review

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

E0250: HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS

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

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes listed above are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for the following specific information to determine if the item billed complies with the existing reasonable and necessary criteria:

- Treating physician's written order prior to delivery (WOPD)
- Documentation to support the beneficiary had a face-to-face examination with the physician, Physician Assistant (PA), Nurse Practitioner (NP) or Clinical Nurse Specialist (CNS) within six months prior to the date of the written order (if applicable)
- Treating physician must sign/co-sign the face-to-face encounter of the PA, NP, or CNS (if applicable)
- Requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain; or,
- Requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or problems with aspiration; or,
- Requires traction equipment, which can only be attached to a hospital bed
- Proof of delivery

- The Advanced Beneficiary Notice (if applicable)
- Any other supporting documentation

Failure to supply the above requested information within 45 days of the date on the letter will result in the claim being denied. Please fax requested documentation and a copy of the ADR letter to 1-701-277-7888 or mail to Noridian LLC P.O. Box 6727 Fargo, ND 58108-6727. The ADR letter provided will also provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Hospital Beds and Accessories Local Coverage Determination (LCD) L11572 and Policy Article A37079.

Additional information, educational opportunities and training tools related to this product category are available on our Training and Events page.

Information about prepay reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Hospital Beds (HCPCS E0260) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0260. The quarterly edit effectiveness results from July 2014 through October 2014 are as follows:

The E0260 review involved 1645 claims, of which 1377 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 86%.

Top Denial Reasons

- The medical documentation submitted did not support the criteria for a semi-electric bed.
- The medical documentation submitted did not support the criteria for a fixed height bed.
- There was no documentation submitted.
- The written order prior to delivery (WOPD) submitted contained an invalid date stamp or equivalent.

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Hospital Beds and Accessories Local Coverage Determination (LCD) L11572 and Policy Article A37079.

Suppliers can also review a specific policy Documentation Checklist for Hospital Beds on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The medical documentation submitted did not support the criteria for a semi-electric bed.

A semi-electric hospital bed is covered if the patient meets one of the criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

The medical documentation submitted did not support the criteria for a fixed height bed.

A fixed height hospital bed is covered if one or more of the following criteria (1-4) are met:

- The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or
- The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
- The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, or
- The patient requires traction equipment, which can only be attached to a hospital bed.

There was no documentation submitted.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

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 to such provider". It is expected that the patient's medical records will reflect the need for the care provided. The patient'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. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and be available upon request.

The WOPD submitted contained an invalid date stamp or equivalent.

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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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 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 Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

Note: 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.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of the completed WOPD with the prescribing physician's signature and signature date.

CEDI ICD-10 End-to-End Frequently Asked Questions

For answers to frequently asked questions on the ICD-10 End-to-End Testing Process, go to the Common Electronic Data Interchange (CEDI) website. The FAQs include information on selecting beneficiary Medicare numbers, National Provider Identifiers (NPIs), dates of service, preparation for testing, and more.

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

MLN Matters® Number: SE1408 Revised

Related Change request (CR) #: 7492

This article was revised on February 20, 2015, to add a question and answer at the bottom of page 2 regarding dual processing of ICD-9 and ICD-10 codes. 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

CMS has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2015, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2015, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 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 (incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), 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
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

Bill Type(s)	Facility Type/ Services	Claims Processing Requirement	Use FROM or THROUGH Date
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
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 an ICD-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

Bill Type(s)	Facility Type/ Services	Claims Processing Requirement	Use FROM or THROUGH Date
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
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.

CMS Conducts Successful Medicare FFS ICD-10 End-to-End Testing Week

CMS Provider Education Message: CMS Conducts Successful Medicare FFS ICD-10 End-to-End Testing Week

From January 26 through February 3, 2015, Medicare Fee-For-Service (FFS) health care providers, clearinghouses, and billing agencies participated in the first successful ICD-10 end-to-end testing week with all Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor. CMS was able to accommodate all volunteers, which represented a broad cross-section of provider, claim, and submitter types.

Approximately 660 providers and billing companies submitted nearly 15,000 test claims. This successful week of testing continues to put us on course for successful implementation of this important initiative that better reflects modern practice of medicine by October 1, 2015.

Testing demonstrated that CMS systems are ready to accept ICD-10 claims. View the results.

Overall, participants in the January 26 to February 3 testing were able to successfully submit ICD-10 claims and have them processed through our billing systems. To the extent that some claims were rejected, most didn't meet the mark because of errors unrelated to ICD-9 or ICD-10.

Testing allows us to identify areas of improvement, and we will work with outside entities and stakeholders to improve those very small deficiencies identified. And, we will continue to do testing, especially in those areas we identify as needing improvement.

In addition to acknowledgement testing, which may be completed at any time, two more end-to-end testing weeks will be held before the October 1, 2015, compliance date for ICD-10:

- April 27 through May 1: Volunteers have been selected
- July 20 through July 24: Volunteer forms will be available March 13 on the MAC and CEDI websites
- Testers who participated in the January testing are automatically eligible to test again in April and July

For more information:

- MLN Matters® Article #MM8867, "ICD-10 Limited End-to-End Testing with Submitters for 2015
- MLN Matters® Special Edition Article #SE1435, "FAQs – ICD-10 End-to-End Testing"
- MLN Matters® Special Edition Article #SE1409, "Medicare FFS ICD-10 Testing Approach"

Coding for ICD-10-CM: More of the Basics Video

In this MLN Connects™ video on Coding for ICD-10-CM: More of the Basics, Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers' understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. The video covers:

- How to assign a diagnosis code using ICD-10-CM
- ICD-10-CM code structure
- Coding process and examples: Combination codes, 7th character, placeholder "x," excludes notes, unspecified codes, external cause codes
- Resources for coders

Keep Up to Date on ICD-10

Visit the Medicare Fee-For-Service Provider Resources web page for a complete list of MLN Connects videos on ICD-10. To receive announcements for MLN Connects videos and the latest Medicare program information, subscribe to the weekly MLN Connects Provider eNews.

Visit the CMS ICD-10 website for the latest news and resources to help you prepare. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

Source: CMSLISTS Email Update dated December 11, 2014

FAQs – ICD-10 Acknowledgement Testing and End-to-End Testing

MLN Matters® Number: SE1501

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies who participate in Medicare ICD-10 acknowledgement testing and who are selected to participate in end-to-end testing.

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies who participate in acknowledgement testing and who are selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 acknowledgement testing and end-to-end testing to gain an understanding of the guidelines and requirements for successful testing. When "you" is used in this publication, we are referring to ICD-10 acknowledgement testers or end-to-end testers.

Question	Acknowledgement Testing	End-to-End Testing
Do I need to register for testing?	No, you do not need to register for acknowledgement testing.	Yes, end-to-end testing volunteers must register on their Medicare Administrative Contractor (MAC) website during specific time periods.
Who can participate in testing?	Acknowledgement testing is open to all Medicare Fee-For-Service (FFS) electronic submitters.	End-to-end testing is open to: • Medicare FFS direct submitters; • Direct Data Entry (DDE) submitters who receive an Electronic Remittance Advice (ERA); • Clearinghouses; and • Billing agencies.

Question	Acknowledgement Testing	End-to-End Testing
How many testers will be selected?	All Medicare FFS electronic submitters can acknowledgement test.	50 end-to-end testers will be selected per MAC jurisdiction for each testing round. **You must be selected by the MAC for this testing.**
What will the testing show?	The goal of acknowledgement testing is to demonstrate that: • Providers and submitters can submit claims with valid ICD-10 codes and ICD-10 companion qualifier codes; • Providers submitted claims with valid National Provider Identifiers (NPIs) • The claims are accepted by the Medicare FFS claims systems; and • Claims receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.	The goal of end-to-end testing is to demonstrate that: • Providers and submitters can successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems; • Software changes the Centers for Medicare & Medicaid Services (CMS) made to support ICD-10 result in appropriately adjudicated claims; and • Accurate Remittance Advices are produced.
Will the testing test National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)?	No, acknowledgment testing will not test NCDs and LCDs.	Yes, end-to-end test claims will be subject to all NCDs and LCDs.
Will the testing confirm payment and return an ERA to the tester?	No, acknowledgement testing will not confirm payment. Test claims will receive 277CA or 999 acknowledgement, as appropriate, to confirm that the claim was accepted or rejected by Medicare.	Yes, end-to-end testing will provide an ERA based on current year pricing.
How many claims can testers submit?	There is no limit on the number of acknowledgement test claims you can submit.	You may submit 50 end-to-end test claims per test week.
How do testers submit claims for testing?	You submit acknowledgement test claims directly or through a clearinghouse or billing agency with test indicator "T" in the Interchange Control Structure (ISA) 15 field.	You submit end-to-end test claims directly with test indicator "T" in the ISA15 field or through DDE.
When should testers submit test claims?	You may submit acknowledgement test claims anytime. We encourage you to test during the highlighted testing weeks: • March 2 – 6, 2015 • June 1 – 5, 2015	You must submit end-to-end test claims during the following testing weeks: • January 26 – 30, 2015 • April 27 – May 1, 2015 • July 20 – 24, 2015

Question	Acknowledgement Testing	End-to-End Testing
What dates of service do testers	You must use current dates of service	You must use the following future dates of service during end-to-end testing: • Professional claims – Dates of service on or after October 1, 2015 • Inpatient claims – Discharge dates on or after October 1, 2015 • Supplier claims – Dates of service between October 1, 2015, and October 15, 2015 • Professional and institutional claims – Dates up to December 31, 2015. You cannot use dates in 2016 or beyond

Remember that you must be selected by the MAC in order to participate in end-to-end testing.

Resources

The chart below provides ICD-10 resource information.

For More Information About…	Resource
ICD-10	http://www.cms.gov/Medicare/Coding/ICD10/index.html website
ICD-10 Information for Medicare Fee-For-Service Providers	http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html on the CMS website
ICD-10 Implementation Timelines	http://www.cms.gov/Medicare/Coding/ICD10/ICD-10ImplementationTimelines.html on the CMS website
ICD-10 Statute and Regulations	http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html on the CMS website
All Available Medicare Learning Network® (MLN) Products	"Medicare Learning Network® Catalog of Products" located on the CMS website at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Patients	http://www.medicare.gov on the CMS website

Additional Information

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

ICD-10 End-to-End Testing – FAQS – Revised

MLN Matters® Number: SE1435 Revised

This article was revised on December 24, 2014, to add FAQs 6-8 on page 3 and the former FAQ 6 is now FAQ 9. All other information remains the same.

Provider Types Affected

This MLN Matters® Special Edition article is intended for all physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing.

Provider Action Needed

Physicians, providers, suppliers, clearinghouses, and billing agencies selected to participate in Medicare ICD-10 end-to-end testing should review the following questions and answers before preparing claims for ICD-10 end-to-end testing to gain an understanding of the guidelines and requirements for successful testing.

What to Know Prior to Testing

1. **How is ICD-10 end-to-end testing different from acknowledgement testing?**

   The goal of acknowledgement testing is for testers to submit claims with ICD-10 codes to the Medicare Fee-For-Service claims systems and receive acknowledgements to confirm that their claims were accepted or rejected.

   End-to-end testing takes that a step further, processing claims through all Medicare system edits to produce and return an accurate Electronic Remittance Advice (ERA). While acknowledgement testing is open to all electronic submitters, end-to-end testing is limited to a smaller sample of submitters who volunteer and are selected for testing.

2. **What constitutes a testing slot for this testing?**

   A testing slot is the ability to submit 50 claims to a particular Medicare Administrative Contractor (MAC) who selected you for testing.

3. **What data must I provide to the MAC before testing?**

   For each testing slot, you must provide the MAC: up to 2 submitter identifiers (IDs), up to 5 National Provider Identifiers (NPIs)/Provider Transaction Access Numbers (PTANs), and up to 10 Health Insurance Claim Numbers (HICNs). You may use these in any combination on the 50 claims. You will need to use the same HICN on multiple claims. Therefore, you will need to consider this when designing a test plan, since claims will be subject to standard utilization edits.

   If you were selected to test with only one submitter ID but would like to choose a second one, you must contact the MAC to add the second submitter ID. If the MAC is not aware of your preference to use a second submitter ID, claims submitted with that ID may not be processed.

4. **What should I consider when choosing HICNs for testing?**

   The MAC will copy production information into the test region for the HICNs that you provide. This includes eligibility information, claims history, and other documentation such as Certificates of Medical Necessity (CMNs). The HICNs you provide must be real beneficiaries and may not have a Date of Death on file. If you previo/usly submitted HICNs for beneficiaries who are deceased, contact the MAC as soon as possible with replacement HICNs.

5. **If I was selected for the January 2015 end-to-end testing, do I need to reapply for later testing rounds?**

   No, once you are selected for testing, you are automatically registered for the later rounds of testing.

6. **Does this mean that no new submitters will be accepted for the April and July 2015 end-to-end testing periods or will a new group of 850 testers be selected for both April and July?**

   A new group will be selected for each of the April and July 2015 testing periods, and these groups will be able to test in addition to the already chosen testers. Therefore, the total number of potential testers will be 1,700 for April 2015 and 2,550 for July 2015.

7. **Do you have information on who has been selected for the January 2015 end-to-end testing?**

   We will release this information as part of the public release of our January test results.

8. **When do you expect to publically release results of the first round of end-to-end testing?**

   We expect to publically release results of the first round of end-to-end testing around the end of February 2015.

9. **Can I submit additional NPIs, PTANs, and HICNs for the later rounds of testing?**

   Yes, while you do not need to re-apply for the later rounds of testing, you may choose to submit up to 2 additional submitter IDs, up to 5 additional NPIs/PTANs, and up to 10 additional HICNs. You may also still use the information you submitted for the previous testing round. The MAC will provide the form you must use to submit this new information, and the information must be received by the due date on the form to be considered for the next round of testing.

What to Know During Testing

1. **Is it safe to submit test claims with Protected Health Information (PHI)?**

   The test claims you submit are accepted into the system using the same secure method used for production claims on a daily basis. They will be processed by the same MACs who process production claims, and all the same security protocols will be followed. Therefore, using real data for this test does not cause any additional risk of release of PHI.

2. **What Dates of Service can be used on test claims?**

   Professional claims with an ICD-10 code must have a date of service on or after October 1, 2015.

   Inpatient claims with an ICD-10 code must have a discharge date on or after October 1, 2015.

   Supplier claims with an ICD-10 code must have a date of service between October 1, 2015, and October 15, 2015.

For professional and institutional claims, you may use dates up to December 31, 2015. You cannot use dates in 2016 or beyond.

3. **Can both ICD-9 and ICD-10 codes be submitted on the same claim?**

   ICD-9 and ICD-10 codes cannot be submitted on the same claim. For additional information on how to submit claims that span the ICD-10 implementation date (when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later), please refer to MLN Matters® Article SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that span the ICD-10 Implementation Date" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf on the Centers for Medicare & Medicaid Services website.

4. **Do Returned to Provider (RTP) claims count toward the 50 claims submitted? Can RTP'd claims be re-submitted for testing?**

   Institutional claims that fail Return to Provider (RTP) editing count toward the 50 claim submission limit. Claims that are RTP'd will not appear on the electronic remittance advice, and will not be available through DDE. If claims accepted by the front end edits do not appear on the remittance advice, please contact the Medicare Administrative Contractor (MAC) for further information.

   Claims that are rejected by front end editing do not count toward the 50 claim submission limit; therefore, they should be corrected and resubmitted.

5. **If a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required for a supplier claim, do I need to submit a CMN during testing?**

   If the beneficiary has a valid CMN or DIF on file for that equipment/supply covered by the dates of service on your test claim (after 10/1/2015), you do not need to submit a new CMN/DIF.

   If the beneficiary's CMN/DIF has expired for the dates of service on your test claim (after 10/1/2015), you must submit a revised CMN/DIF to extend the end date for that CMN/DIF.

If the beneficiary does not have a CMN or DIF for that equipment/supply, you must submit a new CMN/DIF.

6. **For Home Health claims, how should I submit the Request for Anticipated Payment (RAP) and final claim for testing?**

   Submit the RAP and final claim in the same file and the system will allow them to process. The final claim will be held and recycle (as in normal processing) until the RAP finalizes. It will then be released to the Common Working File (CWF). The RAP processing time will be short since the test beneficiaries are set up in advance.

   To get your results more quickly, you may also want to consider billing Low Utilization Payment Adjustment claims with four visits or less that do not require a RAP.

7. **For Hospice claims, should I submit the Notice of Election (NOE) prior to testing?**

   You will not need to provide NOEs to the MAC prior to the start of testing. The MACs will set up NOEs for any hospice claims received during testing.

8. **For an Inpatient Rehabilitation Facility (IRF) or Skilled Nursing Facility (SNF) stay, can the Case-Mix Group (CMG) or Resource Utilization Group (RUG) code be submitted on the claim even though the date of service is in the future?**

   Yes, you can send the IRF claim with a valid CMG code on the claim and a SNF claim with a valid RUG code on the claim, even though the date is in the future. For testing purposes, only a claim with a valid Health Insurance Prospective Payment System (HIPPS) code will be required. You do not need to submit the supporting data sheets.

ICD-10 News: CMS Resources

CMS ICD-10 Resources

The Centers for Medicare & Medicaid Services (CMS) offers resources to help the health care community prepare for the October 1, 2015, ICD-10 transition. No matter where you are in the process, CMS has resources to help you prepare.

ICD-10 Basics

Basic resources are a great place to start if you are looking for the background and benefits of the ICD-10 transition. These resources include overviews tailored by audience, including small and rural practices, payers, and non-covered entities.

- The ICD-10 Transition: An Introduction
- ICD-10 Basics for Medical Practices
- ICD-10 Basics for Small and Rural Practices
- ICD-10 Basics for Payers
- The ICD-10 Transition: Focus on Non-Covered Entities

Communicating About ICD-10

Communication between health care providers, software vendors, clearinghouses, and billing services is vital to a successful transition. Learn how to get the conversation started with these resources:

- Talking to Your Vendors About ICD-10: Tips for Medical Practices
- Questions to Ask Your Systems Vendors about ICD-10
- The Role of Clearinghouses in ICD-10
- Talking to Your Customers About ICD-10: Tips for Software Vendors

Road to 10

Available on the Provider Resources page, the "Road to 10" tool is an online resource built with input from providers in small practices. Intended to help small medical practices jumpstart their ICD-10 transition, "Road to 10" includes specialty references and the capability to build tailored action plans.

Medscape Education Modules

CMS has released two videos and an expert column to help providers prepare for ICD-10. These Medscape education modules offer an overview of ICD-10 for small practices. Continuing medical education (CME) and nursing continuing education (CE) credits are available to providers who complete these resources. Anyone with a free Medscape account can receive a certificate of completion. You can find these resources on the Provider Resources page.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website for the latest news and resources to help you prepare. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

Source: CMSLISTS Email Update dated January 23, 2015

ICD-10 Testing Approach – Revised

This article was revised on December 8, 2014, to include the dates and some additional details for the three end-to-end testing periods.

MLN Matters® Number: SE1409 Revised

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 International Classification of Diseases, 10th Edition (ICD-10) codes must be used for dates of service on and after October 1, 2015. Be sure you are ready. This MLN Matters® Special Edition article is intended to convey the testing approach that the Centers for Medicare & Medicaid Services (CMS) is taking for ICD-10 implementation.

Background

The implementation of ICD-10 represents a significant code set change that impacts the entire health care community. As the ICD-10 implementation date of October 1, 2015, approaches, CMS is taking a comprehensive four-pronged approach to preparedness and testing for ICD-10 to ensure that CMS as well as the Fee-For-Service (FFS) provider community is ready.

When "you" is used in this publication, we are referring to the FFS provider community.

The four-pronged approach includes:

- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

Each approach is discussed in more detail below.

CMS Internal Testing of Its Claims Processing Systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:

- Alpha testing is performed by each FFS claims processing system maintainer for 4 weeks;
- Beta testing is performed by a separate Integration Contractor for 8 weeks; and
- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-Initiated Beta Testing Tools

To help you prepare for ICD-10, CMS recommends that you leverage the variety of Beta versions of its software that include ICD-10 codes as well as National Coverage Determination (NCD) and Local Coverage Determination (LCD) code crosswalks to test the readiness of your own systems. The following testing tools are available for download:

- NCDs and LCDs converted from International Classification of Diseases, 9th Edition (ICD-9) to ICD-10 located at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html on the CMS website;
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html on the CMS website. On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and
- A pilot version of the October 2013 Integrated Outpatient Code Editor (IOCE) that utilizes ICD-10-CM located at http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/Downloads/ICD-10-IOCE-Code-Lists.pdf on the CMS website. The final version of the IOCE that utilizes ICD-10-CM is scheduled for release in the near future.

Acknowledgement Testing

Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims anytime up to the October 1, 2015, implementation date. In addition, CMS will be highlighting this testing by offering three separate weeks of ICD-10 acknowledgement testing. These special acknowledgement testing weeks give submitters access to real-time help desk support and allows CMS to analyze testing data. Registration is not required for these virtual events.

All MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor will promote this ICD-10 acknowledgement testing with trading partners. This testing allows all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will be able to accept their claims with ICD-10 codes. While test claims will not be adjudicated, the MACs will return an acknowledgment to the submitter (a 277A or a 999) that confirms whether the submitted test claims were accepted or rejected.

MACs and CEDI will be appropriately staffed to handle increased call volume on their Electronic Data Interchange (EDI) help desk numbers, especially during the hours of 9:00 a.m. to 4:00 p.m. local MAC time, during these testing weeks. The testing weeks will occur in November 2014, March 2015, and June 2015. For more information about acknowledgement testing, refer to the information on your MAC's website.

End-to-End Testing

During 2015, CMS plans to offer three separate end-to-end testing opportunities. Each opportunity will be open to a limited number of providers that volunteer for this testing. As planned, approximately 2,550 volunteer submitters will have the opportunity to participate over the course of the three testing periods. End-to-end testing includes the submission of test claims to Medicare with ICD-10 codes and the provider's receipt of a Remittance Advice (RA) that explains the adjudication of the claims. The goal of this testing is to demonstrate that:

- Providers or submitters are able to successfully submit claims containing ICD-10 codes to the Medicare FFS claims systems;
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims (based on the pricing data used for testing purposes); and
- Accurate RAs are produced.

The sample will be selected from providers, suppliers, and other submitters who volunteer to participate. To facilitate this testing, CMS requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.
- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. At least five, but not more than fifteen, of the testers will be a clearinghouse.
- MACs and CEDI will post a volunteer form to their website during the enrollment periods to collect volunteer information with which to select volunteers. Those interested in testing should review the minimum testing requirements on the form to ensure they qualify before volunteering.

Additional details about the end-to-end testing process will be disseminated at a later date in a separate MLN Matters® article.

Claims Submission Alternatives

If you will not be able to complete the necessary systems changes to submit claims with ICD-10 codes by October 1, 2015, you should investigate downloading the free billing software that CMS offers via their MAC websites. The software has been updated to support ICD-10 codes and requires an internet connection. 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. Alternatively, all MACs offer provider internet portals, and a subset of these MAC portals offer claims submission; providers submitting to this subset of MACs may choose to use the portal for submission of ICD-10 compliant claims. Register in the portals that offer claims submission to ensure that you have the flexibility to submit professional claims this way as a contingency. More information may be found on your MAC's website.

Additional Information

If you have any questions, please contact your MAC at their toll-free number. That number is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html under - How Does It Work. In addition to showing the toll-free numbers, you will find your MAC's website address at this site in the event you want more information on the free billing software or the MAC's provider internet portals mentioned above.

ICD-10 Limited End to End Testing with Submitters for 2015

MLN Matters® Number: MM8867
Related Change Request (CR) #: CR 8867
Related CR Release Date: January 20, 2015
Related CR Transmittal #: R1451OTN

EFFECTIVE DATES: September 12, 2014 - for MACs and CEDI (non-systems change requirements) (Note: This is the due date of the first MAC and CEDI requirement); January 26, 2015 - for FISS and CEDI coding for January Testing Week; April 27, 2015 - for FISS and CEDI coding for April Testing Week; July 20, 2015 - for FISS and CEDI coding for July Testing Week.

IMPLEMENTATION DATES: January 5, 2015 - for FISS and CEDI coding for January Testing Week; February 16, 2015 - for MAC requirements for the January 15 testing. This is the due date of the last MAC deliverable.; April 6, 2015 - for FISS and CEDI coding for April Testing Week; May 18, 2015 - for MAC requirements for the April 15 testing. This is the due date of the last MAC deliverable.; July 6, 2015 - for FISS and CEDI coding for July Testing Week; August 10, 2015 - for MAC requirements for the July 15 testing. This is the due date of the last MAC deliverable.

Provider Types Affected

This MLN Matters® Article is intended for providers and clearinghouses wishing to submit test claims with ICD-10 codes to Medicare Administrative Contractors (MACs).

What You Need to Know

Change Request (CR) 8867 directs MACs to test with a limited number of providers and clearinghouses to ensure claims with ICD-10 codes can be processed from submission to remittance. This additional testing effort will help ensure a successful transition to ICD-10.

The Centers for Medicare & Medicaid Services (CMS) defines successful end-to-end testing as being able to demonstrate that:

- Testing entities are able to successfully submit ICD-10 claims to the shared systems,
- Software changes made to support ICD-10 result in appropriately adjudicated claims based on the pricing data employed for testing purposes; and
- Remittance advices are produced.

Make sure your billing staffs are aware of this update.

Background

The International Classification of Disease, Tenth Revision, (ICD-10) must be implemented by October 1, 2015. While system changes to implement this project have been completed and tested in previous releases, the industry has requested the opportunity to test with CMS.

CR8867 will allow a small subset of submitters to test with MACs and the Common Electronic Data Interchanges (CEDIs) in three testing periods to demonstrate to the industry that CMS systems are ready for the ICD-10 implementation. MACs and CEDI shall conduct three limited End-to-End testing weeks with a small subset of submitters.

To facilitate this testing, CR8867 requires MACs to do the following:

- Conduct limited end-to-end testing with submitters in three testing periods; January 2015, April 2015 and July 2015. Test claims will be submitted January 26 – 30, 2015, April 27 – May 1, 2015, and July 20 – 24, 2015.

- Each MAC (and CEDI with assistance from DME MACs) will select 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. The Railroad Retirement Board (RRB) contractor will also select 50 submitters. Testers will be selected randomly from a list of volunteers. At least five, but not more than fifteen of the testers will be a clearinghouse, and submitters should be a mix of provider types.
- MACs and CEDIs will post a volunteer form to their website to collect volunteer information with which to select volunteers.
    - Form verifies testers are ready to test, meet the requirements to test, and collect data about the tester. (How they submit claims, what types of claims they will submit, and so forth.)
    - MACs and CEDIs will post the form to their website by March 13, 2015, for the July 2015 testing.
    - Volunteers must submit completed forms to the MACs and CEDIs by April 17, 2015, for the July 2015 testing.
- By May 8, 2015, for the July 2015 testing, the MACs and CEDIs (for the DME MACs) will notify the volunteers that they have been selected to test and provide them with the information needed for the testing, such as:
    - How to submit test claims (for example, what test indicators should be set);
    - What dates of service may be used for testing;
    - How many claims may be submitted for testing (Test claims volume is limited to a total of 50 claims for the entire testing week, submitted in no more than three files);
    - Request for National Provider Identifiers (NPIs) and Health Insurance Claim Numbers (HICNs) that will be used in testing (no more than five NPIs and 10 HICNs per submitter);
    - Notice that if more than 50 claims are submitted, they may not be processed;
    - Notice that claims submitted with NPIs or HICNs not previously submitted for testing, likely will not be completed; and
    - Notice of potential Protected Health Information (PHI) on test remittances not submitted (and instructions to report PHI found to the MAC).
- MACs and CEDIs (for the DME MACs) will collect information from the testers after they have been notified of their selection, using a form provided by CMS. This form will specifically request the Health Insurance Claim Numbers (HICNs), Provider Transaction Access Number (PTANs), and National Provider Identifiers (NPIs) the tester will use during testing. Testers shall submit these forms back to the MAC/CEDI by February 20, 2015, for the April 2015 testing, and by May 29, 2015, for the July 2015 testing. Notification will warn testers that if forms are not received timely, they may lose their opportunity to test.
- Testers selected in the January 2015 Testing may participate in the April 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 testers of this option 30 days prior to the start of the April 2015 testing, using language provided by CMS.
- Testers selected in the January 2015 and April 2015 Testing may participate in the July 2015 testing, and may submit an additional 50 test claims using the same HICNs and NPIs provided previously. MACs shall send a reminder to the January 2015 and April 2015 testers of this option 30 days prior to the start of the July 2015 testing, using language provided by CMS.
- MACs and CEDI will work with the testers selected to ensure they are prepared to test, and understand the requirements for testing.
- MACs and CEDI will instruct the testers to submit up to a total of 50 test claims during the testing period. This may be submitted in one to three files, but the total number of test claims cannot exceed 50.

- CEDI will instruct suppliers to submit claims with ICD-10 code with Dates of Service October 1, 2015, through October 15, 2015. They may also submit claims with ICD-9 codes with Dates of Service before October 1, 2015.
    - MACs will instruct testers to submit test claims with ICD-10 code with Dates of Service on or after October 1, 2015. They may also submit test claims with ICD-9 codes with Dates of Service before October 1, 2015.
    - MACs and CEDIs will be prepared to support increased call volume from testers during the testing window, and up to 2 weeks following the receipt of the ERAs from testing.
- MACs and CEDIs will provide information to the testers on who to contact for testing questions. This may be separate contacts for front end questions and remittance questions.
- MACs and CEDIs will post an announcement about the testing to their websites. The announcement will be provided by CMS.

Additional Information

The official instruction, CR8867 issued to your MAC regarding this change is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1451OTN.pdf on the CMS website.

You may also want to review MLN Matters® Article SE1409, which discusses ICD-10 testing. That article is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1409.pdf on the CMS website.

New ICD-10 Videos

The Centers for Medicare & Medicaid Services (CMS) has released two animated shorts that explain key ICD-10 concepts.

Less than 4 minutes each, the videos are available at cms.gov/ICD-10:

- "Introduction to ICD-10 Coding" gives an overview of ICD-10's features and explains the benefits of the new code set to patients and to the health care community.
- "ICD-10 Coding and Diabetes" uses diabetes as an example to show how the code set captures important clinical details.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website for the latest news and resources to help you prepare. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

Source: CMSLISTS Email Update dated 02/19/15

LCD and Policy Article Revisions Summary for February 19, 2015

Outlined below are the principal changes to a DME MAC Local Coverage Determinations (LCD) and a Policy Article (PA) that have been revised and posted. Please review the entire LCD and each related PA for complete information.

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Coverage for Levodopa-Carbidopa enteral suspension (effective for dates of service on or after 01/09/2015)

Added: Coverage for Blinatumomab (effective for dates of service on or after 12/03/2014)

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

HCPCS CODES AND MODIFIERS:

Added: Codes A4602 and J2274

Deleted: Codes J2271 and J2275

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Group 4 Paragraph:

Added: HCPCS Code for Levodopa-Carbidopa enteral suspension

Group 4 Codes:

Added: ICD-9 Code 332.0

Group 5 Paragraph:

Added: HCPCS Code for Blinatumomab

Group 5 Codes:

Added: ICD-9 Code 204.02

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for equipment retained from a prior payer
Added: Repair /Replacement section

Policy Article

Revision Effective Date: 01/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "When required by state law" from ACA new prescription requirements

Revised: Face-to-Face Requirements for treating practitioner

CODING GUIDELINES:

Added: Coding requirements for lithium batteries

Deleted: References to codes J2271 and J2275

Added: Levodopa-Carbidopa enteral suspension (effective for dates of service on or after 01/09/2015)

Added: Blinatumomab (effective for dates of service on or after 12/03/2014)

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

LCD and Policy Article Revisions Summary for February 26, 2015

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

Lower Limb Prostheses

LCD

Revision Effective Date: 01/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Added: Standard language regarding Medicare coverage

HCPCS CODING:

Revised: HCPCS Narrative of L7367

DOCUMENTATION REQUIREMENTS:

Added: Continued need, continued use, and Prior Payer verbiage and updated standard language documentation

Revised: Repair/Replacement verbiage

Power Mobility Devices

LCD

Revision Effective Date: 01/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility

HCPCS CODES:

Revised: HCPCS Narrative for E0986

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Instructions for equipment retained from a prior payer and repair/replacement verbiage

Policy Article

Revision Effective Date: 01/01/2015

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: HCPCS Narrative for E0986 and updated standard language documentation

Refractive Lenses

LCD

Revision Effective Date: 01/01/2015

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Standard Documentation Language regarding Medicare coverage

HCPCS CODING:

Revised: HCPCS V2799 Narrative

DOCUMENTATION REQUIREMENTS:

Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

Added: Continued need, continued use, request for refill documentation requirements and repair/replacement

Revised: Changed ICD-9 reference to diagnosis

Policy Article

Revision Effective Date: 05/01/2013 (February 2015 Publication)

Removed: Reference to ICD-9 located in the narrative

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

MOBILITY DEVICES

Manual Wheelchairs (HCPCS K0001, K0003, K0004) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes K0001, K0003 and K0004. The quarterly edit effectiveness results from July 2014 through October 2014 are as follows:

The K0001 review involved 857 claims, of which 709 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 80%.

The K0003 review involved 406 claims, of which 385 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 91%.

The K0004 review involved 202 claims, of which 187 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 86%.

Top Denial Reasons

- The written order prior to delivery (WOPD) submitted contained an invalid date stamp or equivalent.
- The documentation submitted did not support that the beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.
- The documentation submitted did not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- A home assessment to determine that the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided was not submitted or was invalid.
- The documentation submitted did not support that the beneficiary requires a lightweight wheelchair (K0003).
- The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Manual Wheelchair Bases Local Coverage Determination (LCD) L11454 and Policy Article A25378.

Suppliers can also review a specific policy Documentation Checklist for Manual Wheelchairs on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The WOPD submitted contained an invalid date stamp or equivalent.

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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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 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 Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

Note: 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.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of the completed WOPD with the prescribing physician's signature and signature date.

The documentation submitted did not support that the beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.

A mobility limitation is one that:

- Prevents the beneficiary from accomplishing an MRADL entirely, or
- Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- Prevents the beneficiary from completing an MRADL within a reasonable time frame.

The documentation submitted did not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker (Criterion B).

A home assessment to determine that the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided was not submitted or was invalid.

Documentation must support that the beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.

Information about whether the beneficiary's home can accommodate the wheelchair (Criterion C), also called the home assessment, must be fully documented in the medical record or elsewhere by the supplier. For manual wheelchairs, the home assessment may be done directly by visiting the beneficiary's home or indirectly based upon information provided by the beneficiary or their designee. When the home assessment is based upon indirectly obtained information, the supplier must, at the time of delivery, verify that the item delivered meets the requirements specified in criterion C. Issues such as the physical layout of the home, surfaces to be traversed, and obstacles must be addressed by and documented in the home assessment. Information from the beneficiary's medical record and the supplier's records must be available upon request.

The documentation submitted did not support that the beneficiary requires a lightweight wheelchair (K0003).

A lightweight wheelchair (K0003) is covered when the documentation supports that the beneficiary meets both criteria (1) and (2):

- Cannot self-propel in a standard wheelchair in the home; and
- The beneficiary can and does self-propel in a lightweight wheelchair

The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).

A high strength lightweight wheelchair (K0004) is covered when the documentation supports that the beneficiary meets criteria (1) or (2):

- The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; or
- The beneficiary requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

PMD Prior Authorization Requests Top Reasons for Non-Affirmation

The Jurisdiction D DME MAC Medical Review department provides suppliers the opportunity to request prior authorization for select power mobility devices (PMDs) per the PMD demonstration guidelines. The top reasons for non-affirmation from September 2014 through November 2014 are indicated below.

Top Reasons for Non-Affirmed Decisions

- The face-to-face examination does not indicate that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home.
- When a power wheelchair is requested, the face-to-face examination documentation does not indicate that the use of a power operated vehicle (POV) has been excluded.
- The face-to-face examination does not indicate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.
- The face -to-face examination does not indicate the beneficiary is able to safely transfer to and from the power mobility device.
- The face -to-face examination does not indicate the beneficiary is able to operate the tiller steering system of the power mobility device.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Power Mobility Devices Local Coverage Determination (LCD) L23598 and Policy Article A41127.

Suppliers can also review resources for the Prior Authorization Demonstration on the Noridian website. There you will find information related to Prior Authorization Request (PAR) Demonstration including how to submit PARs, documentation and educational resources, CMS Resources, and the HCPCS codes that are eligible for the PAR demonstration.

Noridian also provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The face-to-face examination does not indicate that the beneficiary's limitation of upper extremity function is insufficient to self-propel an optimally-configured manual wheelchair in the home in order to perform mobility-related activities of daily living (MRADLs).

The beneficiary's medical documentation does not support criterion C per LCD L23598.

The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day.

Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

When a POV is requested, the face-to-face examination does not indicate that the use of a POV has been excluded.

The beneficiary's medical documentation does not support criterion D per LCD L23598.

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

The beneficiary is able to:

- Safely transfer to and from a POV, and
- Operate the tiller steering system, and
- Maintain postural stability and position while operating the POV in the home.

The face-to-face examination does not indicate the beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker.

The beneficiary's medical documentation does not support criterion B per LCD L23598.

The face-to-face examination does not indicate the beneficiary is able to safely transfer to and from the power mobility device.

When a POV is requested, the face -to-face examination does not indicate the beneficiary is able to safely transfer to and from the power mobility device.

The beneficiary's medical documentation does not support criterion D per LCD L23598.

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

The beneficiary is able to:

- Safely transfer to and from a POV, and
- Operate the tiller steering system, and
- Maintain postural stability and position while operating the POV in the home.

The face -to-face examination does not indicate the beneficiary is able to operate the tiller steering system of the power mobility device.

The beneficiary's medical documentation does not support criterion D per LCD L23598.

A POV is covered if all of the basic coverage criteria (A-C) have been met and if criteria D-I are also met.

The beneficiary is able to:

- Safely transfer to and from a POV, and
- Operate the tiller steering system, and
- Maintain postural stability and position while operating the POV in the home.

Power Mobility Devices and All Related Accessories (HCPCS K0823) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code K0823 and all related accessories. The quarterly edit effectiveness results from July 2014 through October 2014 are as follows:

The K0823 review involved 299 claims, of which 157 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 53%.

Top Denial Reasons

- The documentation submitted does not support the beneficiary does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair.
- The documentation submitted contained no detailed product description or the detailed product description submitted was invalid.
- The 7-element order submitted was incomplete or missing elements.
- The face-to-face examination submitted was incomplete or missing elements.

Going Forward

Based on the results of this review, Noridian will close the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Power Mobility Devices (PMD) Local Coverage Determination (LCD) L23598 and Policy Article A41127.

Suppliers can also review a specific policy Documentation Checklist for Power Mobility Devices on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The beneficiary's medical records do not support that the beneficiary does not have sufficient upper extremity function to self propel an optimally configured manual wheelchair.

The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform mobility related activities of daily living (MRADL) during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

The documentation submitted contained no detailed product description or the detailed product description submitted was invalid.

Once the supplier has determined the specific power mobility device that is appropriate for the beneficiary based on the physician's 7-element order, the supplier must prepare a written document (termed a detailed product description).

This detailed product description (DPD) must comply with the requirements for a detailed written order as outlined in the Supplier Manual and CMS' Program Integrity Manual (Internet-Only Manual, Pub. 100-8), Chapter 5. 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) dispensed is properly coded.

The physician must sign and date the detailed product description and the supplier must receive it prior to delivery of the PWC or Power Operated Vehicle (POV). A date stamp or equivalent must be used to document the supplier receipt date. The detailed product description must be available on request.

*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.

The 7-element order submitted was incomplete or missing elements.

The order, referred to as the 7-element order, that the supplier must receive within 45 days after completion of the face-to-face examination (see Policy Article) must contain all of the following elements:

- Beneficiary's name
- Description of the item that is ordered. This may be general – e.g., "power operated vehicle", "power wheelchair", or "power mobility device"– or may be more specific.
- Date of the face-to-face examination
- Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
- Length of need
- Physician's signature
- Date of physician signature

The Supplier may provide a template order listing the seven required elements but is prohibited from completing any part of it. The treating physician completing the face-to-face requirements must write the 7-element order. The 7-element order may only be written after the completion of the face-to-face exam requirements. Refer to the Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for information regarding the statutory requirements for PMDs.

A date stamp or equivalent must be used to document receipt date. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, added section 1834(a)(1)(E)(iv) which provides that payment may not be made for a motorized or power wheelchair unless the practitioner who has conducted the face-to-face examination him or herself writes the 7-element order. It is a statutory requirement that all items of the 7-element order be entered specifically by and only by the practitioner who has conducted the face-to-face requirements.

For a POV or power wheelchair to be covered, the supplier must receive from the treating physician a written order, termed the 7-element order, containing all the elements specified in the Documentation Requirements section of the Local Coverage Determination within 45 days after completion of the physician's face-to-face examination and prior to delivery of the device. (Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 45 days after discharge.) If these requirements are not met, the claim will be denied as non-covered.

The face-to-face examination submitted was incomplete or missing elements.

For a power operated vehicle (POV) or power wheelchair (PWC) to be covered, the treating physician must conduct a face-to-face examination of the beneficiary before writing the order and the supplier must receive a written report of this examination within 45 days after completion of the face-to-face examination and prior to delivery of the device.

The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

History of the present condition(s) and past medical history that is relevant to mobility needs

- Symptoms that limit ambulation
- Diagnoses that are responsible for these symptoms
- Medications or other treatment for these symptoms

- Progression of ambulation difficulty over time
- Other diagnoses that may relate to ambulatory problems
- How far the beneficiary can walk without stopping
- Pace of ambulation
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used
- What has changed to now require use of a power mobility device
- Ability to stand up from a seated position without assistance
- Description of the home setting and the ability to perform activities of daily living in the home

Physical examination that is relevant to mobility needs

- Weight and height
- Cardiopulmonary examination
- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

The evaluation should be tailored to the individual beneficiary's conditions. The history should paint a picture of the beneficiary's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the beneficiary's ambulatory difficulty or impact on the beneficiary's ambulatory ability.

Physicians shall document the examination in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility examination.

If the report of a licensed/certified medical professional (LCMP) examination is to be considered as part of the face-to-face examination (see Policy Article), there must be a signed and dated attestation by the supplier or LCMP that the LCMP has no financial relationship with the supplier.

A date stamp or equivalent must be used to document the date that the supplier receives the report of the face-to-face examination. The written report of this examination must be available upon request.

Manual Wheelchairs (HCPCS K0001, K0003, K0004) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes K0001, K0003 and K0004. The quarterly edit effectiveness results from October 2014 through January 2015 are as follows:

The K0001 review involved 799 claims, of which 616 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 73%.

The K0003 review involved 355 claims, of which 319 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 87%.

The K0004 review involved 193 claims, of which 177 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 84%.

Top Denial Reasons

- The documentation submitted did not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
- The documentation submitted did not support that the use of a manual wheelchair will significantly improve the beneficiary's ability to participate in mobility related activities of daily living (MRADLs) and the beneficiary will use it on a regular basis in the home.
- The documentation submitted did not support that the beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.
- The documentation submitted did not support that the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.
- The documentation submitted did not support that the beneficiary requires a lightweight wheelchair (K0003).
- The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Manual Wheelchair Bases Local Coverage Determination (LCD) L11454 and Policy Article A25378.

Suppliers can also review a specific policy Documentation Checklist for Manual Wheelchairs on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The documentation submitted did not support that the beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker (Criterion B).

The documentation submitted did not support that the use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.

Use of a manual wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home (Criterion D).

The documentation submitted did not support that the beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day.

The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function (Criterion F).

The documentation submitted did not support that the beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair (Criterion G).

The documentation submitted did not support that the beneficiary requires a lightweight wheelchair (K0003).

A lightweight wheelchair (K0003) is covered when the documentation supports that the beneficiary meets both criteria (1) and (2):

- Cannot self-propel in a standard wheelchair in the home; and
- The beneficiary can and does self-propel in a lightweight wheelchair

The documentation submitted did not support that the beneficiary requires a high strength light weight wheelchair (K0004).

A high strength lightweight wheelchair (K0004) is covered when the documentation supports that the beneficiary meets criteria (1) or (2):

- The beneficiary self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair; or
- The beneficiary requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.

Power Mobility Devices: Coverage Requirements for Criterion C

Failing to supply documentation that supports criterion C for Power Mobility Devices (PMD) coverage is the most common reason for denial of PMD complex medically reviewed claims and Prior Authorization (PA) reviews. The information within this article intends to clarify the documentation requirements for criterion C as defined by the Local Coverage Determination (LCD) for PMD (L23598).

The PMD LCD, L23598, lists criterion C as:

The beneficiary does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair (MWC) in the home to perform MRADLs during a typical day.

- Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
- An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories.

The physical examination should be sufficiently detailed to establish a clear picture of the beneficiary's physical abilities, as well as limitations, that specifically impact mobility related activities of daily living (MRADLs). The medical records are expected to be individualized to the unique characteristics of each patient.

Examples of documentation that may support criterion C:

- Documentation of objective or quantifying information of upper extremity strength, endurance, range of motion, pain or coordination issues that may inhibit the beneficiary's ability to self propel an optimally-configured manual wheelchair.
- If pain is a contributing factor for the need of a PMD, objective documentation should indicate the location, severity, contributing factors and alleviating factors of pain as it relates to propelling an optimally configured manual wheelchair.
- If endurance is a contributing factor for the need of a PMD, documentation should include objective, quantified endurance related information and describe how endurance may contribute to the inability to propel an optimally configured manual wheelchair i.e., cardiac issues.

- If respiratory issues are a contributing factor for the need of a PMD, documentation should include objective, quantified respiratory related information and describe how respiratory status may contribute to the inability to propel an optimally configured manual wheelchair.
    - If oxygen is used, documentation should include a description of the frequency and use and specific quantifying information about resulting limitations.

Suppliers are encouraged to keep these tips in mind when submitting Prior Authorization Requests (PARs) and when responding to Additional Documentation Requests (ADRs). For additional educational references regarding coverage requirements for PMD visit the PMD Consolidated Resources Page on the Noridian website.

NEBULIZERS

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

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code J7605 and J7626, nebulizer inhalation drugs. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from October 1 through December 31, 2014, resulted in an overall error rate of 54%.

Top Denial Reasons

- Requested documentation was not received by the contractor within the allotted timeframe.
- There were no medical records submitted to support the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9).
- The proof of delivery submitted was invalid.
- The refill requirements were not met.

Going Forward

Based on the results of this review, Noridian will continue with the Documentation Compliance Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Nebulizer LCD L11488 and Policy Article A24942.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation not received within the correct time frame.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

There were no medical records submitted to support the management of obstructive pulmonary disease (ICD-9 diagnosis codes 491.0–508.9).

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 patient's medical records will reflect the need for the care provided. The patient'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.

The proof of delivery submitted was invalid.

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4 and 5, Section 4.26 and 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 durable medical equipment 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.

Suppliers are required to maintain POD documentation in their files. 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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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 record 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.

The refill requirements were not met.

REFILL REQUIREMENTS

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products (A4619, A7003-A7017, A7525, all inhalation medications) 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/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. 100-8, 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 three (3)-month quantity at a time.

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).

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

The Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS code E2402. This review was initiated based on Comprehensive Error Rate Testing (CERT) analysis results.

The E2402 review involved 113 claims, of which 92 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.

Top Denial Reasons

- The documentation submitted did not support the evaluation of and provision for the beneficiary's adequate nutritional status.
- The proof of delivery (POD) submitted was invalid or the proof of delivery submitted was prior to the date of service on the claim.
- The signature requirements were not met for the documentation submitted.

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS codes E2402.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Negative Pressure Wound Therapy Pumps Local Coverage Determination (LCD) L11489 and Policy Article A35425.

Suppliers can also review specific policy resources for Negative Pressure Wound Therapy Pumps on the Noridian website. There, you will find, information related to proper documentation requirements including web-based workshop presentations, self-paced/DME on-demand and Workshop Q & A sessions.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

The documentation submitted did not support the evaluation of and provision for the beneficiary's adequate nutritional status.

A Negative Pressure Wound Therapy pump (E2402) and supplies (A6550, A7000) are covered when either criterion A or B is met:

- Ulcers and Wounds in the Home Setting: The beneficiary has a chronic Stage III or IV pressure ulcer (see Appendices Section), neuropathic (for example, diabetic) ulcer, venous or arterial insufficiency ulcer, or a chronic (being present for at least 30 days) ulcer of mixed etiology. A complete wound therapy program described by criterion 1 and criteria 2, 3, or 4, as applicable depending on the type of wound, must have been tried or considered and ruled out prior to application of NPWT.
  1. For all ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT:
     - Documentation in the beneficiary's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
     - Application of dressings to maintain a moist wound environment, and
     - Debridement of necrotic tissue if present, and
     - Evaluation of and provision for adequate nutritional status
  2. For Stage III or IV pressure ulcers:
     - The beneficiary has been appropriately turned and positioned, and
     - The beneficiary has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (see LCD on support surfaces), and
     - The beneficiary's moisture and incontinence have been appropriately managed
  3. For neuropathic (for example, diabetic) ulcers:
     - The beneficiary has been on a comprehensive diabetic management program, and
     - Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities
  4. For venous insufficiency ulcers:
     - Compression bandages and/or garments have been consistently applied, and
     - Leg elevation and ambulation have been encouraged
- Ulcers and Wounds Encountered in an Inpatient Setting:
  1. An ulcer or wound (described under A above) is encountered in the inpatient setting and, after wound treatments described under A-1 through A-4 have been tried or considered and ruled out, NPWT is initiated because it is considered in the judgment of the treating physician, the best available treatment option.
  2. The beneficiary has complications of a surgically created wound (for example, dehiscence) or a traumatic wound (for example, pre-operative flap or graft) where there is documentation of the medical necessity for accelerated formation of granulation tissue which cannot be achieved by other available topical wound treatments (for example, other conditions of the beneficiary that will not allow for healing times achievable with other topical wound treatments).

In either situation B-1 or B-2, NPWT will be covered when treatment is ordered to continue beyond discharge to the home setting.

If criterion A or B above is not met, the NPWT pump and supplies will be denied as not reasonable and necessary.

NPWT pumps (E2402) must be capable of accommodating more than one wound dressing set for multiple wounds on a beneficiary. Therefore, more than one E2402 billed per beneficiary for the same time period will be denied as not reasonable and necessary.

A licensed health care professional, for the purposes of this policy, may be a physician, physician's assistant (PA), registered nurse (RN), licensed practical nurse (LPN), or physical therapist (PT). The practitioner should be licensed to assess wounds and/or administer wound care within the state where the beneficiary is receiving NPWT.

The proof of delivery submitted was invalid or the proof of delivery submitted was prior to the date of service on the claim.

POD is a Supplier Standard and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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.

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

Delivery directly to the beneficiary or authorized representative

Delivery via shipping or delivery service

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 slip. The POD record 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 and date of signature
- The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the item is delivered directly by the supplier, the date the beneficiary received the DMEPOS item 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 record must contain the information specified above.

The signature requirements were not met for the documentation submitted.

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

Handwritten Signature - A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance or obligation.

Signature Log - Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.

Signature Attestation Statement - Providers will sometimes include an attestation statement in the documentation they submit. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

ORTHOTICS AND PROSTHETICS

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L1960, L1970, & L4360. The quarterly edit effectiveness results from September 2014 through December 2014 are as follows:

The L1960 review involved 227 claims, of which 188 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 85%.

The L1970 review involved 352 claims, of which 293 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 83%.

The L4360 review involved 1,076 claims, of which 1,061 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 99%.

Top Denial Reasons

- Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed
- No documentation was received in response to Additional Documentation Request (ADR) letter

- The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis
- Documentation submitted was insufficient to support custom coverage criteria
- Documentation submitted was insufficient to support basic coverage criteria
- No proof of delivery submitted

Going Forward

Based on the results of these reviews, Noridian will continue with the Prepayment Service Specific Reviews.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Ankle-Foot/Knee-Ankle-Foot Orthosis Local Coverage Determination (LCD) L142 and Policy Article A19800.

Suppliers can also review a specific policy Documentation Checklist for Ankle-Foot/Knee-Ankle-Foot Orthosis on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.

Items requiring substantial modification by a qualified practitioner (as defined in the related Policy Article Coding Guidelines) are coded as custom fitted (L1910, L1930, L1932, L1951, L1971, L2035, L2112-L2116, L2132-L2136, L4360, L4386, L4396). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Custom fitted orthotics are:

- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

No documentation was received in response to ADR letter.

Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

The treating physician's records did not provide detailed documentation to support medical necessity of a custom orthosis rather than a prefabricated orthosis.

For custom-fabricated orthoses, there must be detailed documentation in the treating physician's records to support medical necessity of custom-fabricated rather than a prefabricated orthosis. This information will be corroborated by the functional evaluation in the orthotist or prosthetist's records. This information must be available upon request.

Documentation submitted was insufficient to support custom coverage criteria.

AFO's and KAFO's that are custom-fabricated are covered for ambulatory beneficiaries when the basic coverage criteria and one of the following criteria are met:

- The beneficiary could not be fit with a prefabricated AFO; or,
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months); or,
- There is a need to control the knee, ankle or foot in more than one plane; or,
- The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury; or,
- The beneficiary has a healing fracture which lacks anatomical integrity or anthropometric proportions.

If a custom-fabricated orthosis is provided but basic coverage criteria and the additional criteria 1-5 for a custom-fabricated orthosis are not met, the custom-fabricated orthosis will be denied as not reasonable and necessary.

Documentation submitted was insufficient to support basic coverage criteria.

Ankle-foot orthoses (AFO) described by codes L1900, L1902–L1990, L2106–L2116, L4350, L4360, L4386 and L4631 are covered for ambulatory beneficiaries with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

No proof of delivery submitted.

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) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare 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.

The proof of delivery 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. (If utilizing a shipping service or mail order.)
- 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 and date of signature
- Evidence of delivery (If utilizing a shipping service or mail order.)

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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.

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

Knee Orthoses (HCPCS L1832, L1833, & L1843) Results of Service Specific Prepayment Probe Review

The Jurisdiction D DME MAC Medical Review Department completed a widespread prepayment probe review of HCPCS codes L1832, L1833, and L1843. This review was being initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The L1832 review involved 111 claims, of which 111 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

The L1833 review involved 100 claims, of which 99 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 98%.

The L1843 review involved 106 claims, of which 106 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 100%.

Top Denial Reasons

- Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.
- The documentation does not support knee instability by examination of the beneficiary and objective description of joint laxity.
- The documentation does not support a recent injury to or surgical procedure on the knee.
- No documentation was received in response to Additional Documentation Request (ADR) letter.

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS codes L1832, L1833, and L1843.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Knee Orthoses Local Coverage Determination (LCD) L27058 and Policy Article A47178.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.

For prefabricated orthoses, there is no physical difference between orthoses coded as custom fitted versus those coded as off-the-shelf. The differentiating factor for proper coding (see definitions in the related Policy Article Coding Guidelines) is the need for "minimal self-adjustment" at the time of fitting by the beneficiary, caretaker for the beneficiary, or supplier. This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training. Items requiring minimal self-adjustment are coded as off-the-shelf orthoses. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category.

Fabrication of an orthosis using CAD/CAM or similar technology without the creation of a positive model with minimal self-adjustment at delivery is considered as Off-the-Shelf (OTS).

Items requiring substantial modification by a qualified practitioner (as defined in the related Policy Article Coding Guidelines) are coded as custom fitted (L1810, L1832, L1843, L1845, L1847). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Claims for custom fitted orthoses (L1810, L1832, L1843, L1845 and L1847) will be denied as incorrect coding, with a statutory denial, when documentation shows that only minimal self-adjustment was required at the time of fitting (see Policy Specific Documentation Requirements section in the LCD).

The following definitions will be used for correct coding of the items described in this Policy Article and related LCD.

OTS orthotics are:

- Items that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- OTS items require minimal self-adjustment for fitting at the time of delivery for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit an individual.
- This fitting does not require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses to fit the item to the individual beneficiary.

The term "minimal self-adjustment" is defined at 42 CFR §414.402 as an adjustment the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training. For example, adjustment of straps and closures, bending or trimming for final fit or comfort (not all-inclusive) fall into this category.

Custom fitted orthotics are:

- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements. A certified orthotist is defined as an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification.

The documentation does not support knee instability by examination of the beneficiary and objective description of joint laxity.

Knee orthoses K0901, K0902, L1832, L1833, L1843 and L1845 are also covered for a beneficiary who is ambulatory and has knee instability due to a condition specified in the ICD-9 Diagnosis Codes That Support Medical Necessity Group 4 Codes section.

For codes K0901. K0902, L1832, L1833, L1843, L1845 and L1850, knee instability must be documented by examination of the beneficiary and objective description of joint laxity (e.g., varus/valgus instability, anterior/posterior Drawer test).

The documentation does not support a recent injury to or surgical procedure on the knee.

A knee immobilizer without joints (L1830), or a knee orthosis with adjustable knee joints (L1832, L1833), or a knee orthosis, with an adjustable flexion and extension joint that provides both medial-lateral and rotation control (K0901, K0902, L1843, L1845), are covered if the beneficiary has had recent injury to or a surgical procedure on the knee(s). Refer to the diagnoses listed in the ICD-9 Diagnosis Codes That Support Medical Necessity Groups 2 or 4 section as applicable.

No documentation was received in response to ADR letter.

Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Lower Limb Prostheses (HCPCS L5980) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L5980. The quarterly edit effectiveness results from August 2014 through November 2014 are as follows:

The L5980 review involved 49 claims, of which 47 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 81%.

Top Denial Reasons

- Documentation does not support the functional level billed on the claim
- Medical record documentation does not support medical need for replacement
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Medical record documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prostheses (LCD) L11453 and Policy Article A25367.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation does not support the functional level billed on the claim.

A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to:

- The beneficiary's past history (including prior prosthetic use if applicable); and
- The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and
- The beneficiary's desire to ambulate.

The records must document the beneficiary's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. It is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

Medical record documentation does not support medical need for replacement.

Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following:

- A change in the physiological condition of the beneficiary; or
- Irreparable wear of the device or a part of the device; or
- The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

No documentation was received in response to ADR letter.

Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Medical record documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time.

A lower limb prosthesis is covered when the beneficiary:

- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and Certificates of Medical Necessity (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.

Lower Limb Prostheses (HCPCS L5981 & L5987) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L5981 & L5987. The quarterly edit effectiveness results from September 2014 through December 2014 are as follows:

- The L5981 review involved 33 claims, of which 28 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 81%.
- The L5987 review involved 50 claims, of which 43 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 80%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation does not support the functional level billed on the claim
- Documentation does not support medical need for replacement item(s)
- Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time
- Documentation does not support the beneficiary is motivated to ambulate
- Documentation does not support medical necessity for the item(s) requested

Going Forward

Based on the results of these reviews, Noridian will continue with the Prepayment Service Specific Reviews.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Lower Limb Prostheses Local Coverage Determination (LCD) L11453 and Policy Article A25367.

Suppliers can also review a specific policy Documentation Checklist for Lower Limb Prostheses on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation does not support the functional level billed on the claim.

A determination of the medical necessity for certain components/additions to the prosthesis is based on the beneficiary's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and treating physician, considering factors including, but not limited to: 1. The beneficiary's past history (including prior prosthetic use if applicable); and 2. The beneficiary's current condition including the status of the residual limb and the nature of other medical problems; and 3. The beneficiary's desire to ambulate.

The records must document the beneficiary's current functional capabilities and his/her expected functional potential, including an explanation for the difference, if that is the case. It is recognized, within the functional classification hierarchy, that bilateral amputees often cannot be strictly bound by functional level classifications.

Documentation does not support medical need for replacement item(s).

Replacement of a prosthesis or prosthetic component is covered if the treating physician orders a replacement device or part because of any of the following: 1. A change in the physiological condition of the beneficiary; or 2. Irreparable wear of the device or a part of the device; or 3. The condition of the device, or part of the device, requires repairs and the cost of such repairs would be more than 60% of the cost of a replacement device, or of the part being replaced.

Documentation did not support the beneficiary will reach or maintain a defined functional state within a reasonable period of time and is motivated to ambulate.

A lower limb prosthesis is covered when the beneficiary:

- Will reach or maintain a defined functional state within a reasonable period of time; and
- Is motivated to ambulate

Information contained directly in the contemporaneous medical record is the source required to justify payment except as noted elsewhere for prescriptions and Certificates of Medical Necessity (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.

No documentation was received in response to ADR letter.

Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Documentation does not support medical necessity for the item(s) requested.

For any item to be covered by Medicare, it must:

- Be eligible for a defined Medicare benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

For the items addressed in the Lower Limb Prostheses (LLP) LCD, 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.

Spinal Orthoses: LSO (HCPCS L0631 & L0637) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes L0631 & L0637. The quarterly edit effectiveness results from September 2014 through December 2014 are as follows:

The L0631 review involved 496 claims, of which 494 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 99%.

The L0637 review involved 483 claims, of which 480 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 99%.

Top Denial Reasons

- Documentation was insufficient to support that substantial modifications were made for the custom fitted item billed
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation was insufficient to support Criteria 1
- No proof of delivery

Going Forward

Based on the results of these reviews, Noridian will continue with the Prepayment Service Specific Reviews.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses: TLSO and LSO Local Coverage Determination (LCD) L11459 and Policy Article A23846.

Suppliers can also review a specific policy Documentation Checklist for Spinal Orthoses on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation is insufficient to support that substantial modifications were made for the custom fitted item billed.

Items requiring substantial modification by a qualified practitioner are coded as custom fitted (L0454, L0456, L0458, L0460, L0462, L0464, L0466, L0468, L0470, L0472, L0488, L0490, L0491, L0492, L0626, L0627, L0630, L0631, L0633, L0635, L0637 and L0639). Documentation must be sufficiently detailed to include, but is not limited to, a detailed description of the modifications necessary at the time of fitting the orthosis to the beneficiary. This information must be available upon request.

Substantial modification is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthotics such as a physician, treating practitioner, an occupational therapist, or physical therapist in compliance with all applicable Federal and State licensure and regulatory requirements.

Custom fitted orthotics are:

- Devices that are prefabricated
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.

No documentation was received in response to ADR letter.

Suppliers have 45 days from the date of the Additional Documentation Request (ADR) letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the NSC. The supplier standards can be found in 424 CFR Section 424.57(c).

Documentation was insufficient to support Criteria 1.

Lumbar Sacral Orthoses (LSO) and Thoracic Lumbar Sacral Orthoses (TLSO) are covered under the Braces benefit category (Social Security Act §1861(s)(9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. Items that do not meet the definition of a brace are noncovered.

In order for a beneficiary's orthosis to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met.

A spinal orthosis (L0450 - L0651) is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or
- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.
- No proof of delivery.

Proof of delivery (POD) is a Supplier Standard and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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.

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.

The proof of delivery 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. (If utilizing a shipping service or mail order.)
- 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 and date of signature
- Evidence of delivery (If utilizing a shipping service or mail order.)

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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.

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

Spinal Orthoses: TLSO & LSO (HCPCS L0648 & L0650) Results of Service Specific Prepayment Probe Review

The Jurisdiction D, DME MAC, Medical Review Department completed a widespread prepayment probe review of HCPCS codes L0648 and L0650. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis and previous review results.

The L0648 review involved 104 claims, of which 73 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 71%.

The L0650 review involved 99 claims, of which 78 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 79%.

Top Denial Reasons

- Documentation was insufficient to support criteria 1
- No documentation was received in response to Additional Documentation Request (ADR) letter
- No detailed written order (DWO) was submitted
- Invalid proof of delivery

Going Forward

Based on high error rate, Noridian will close this probe review and begin a widespread targeted review on HCPCS codes L0648 and L0650.

Education Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Spinal Orthoses: TLSO & LSO Local Coverage Determination (LCD) L11459 and Policy Article A23846.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation was insufficient to support criteria 1.

Lumbar Sacral Orthoses (LSO) and Thoracic Lumbar Sacral Orthoses (TLSO) are covered under the Braces benefit category (Social Security Act §1861(s) (9)). For coverage under this benefit, the orthosis must be a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It must provide support and counterforce (i.e., a force in a defined direction of a magnitude at least as great as a rigid or semi-rigid support) on the limb or body part that it is being used to brace. Items that do not meet the definition of a brace are noncovered.

In order for a beneficiary's orthosis to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met.

A spinal orthosis (L0450 - L0651) is covered when it is ordered for one of the following indications:

- To reduce pain by restricting mobility of the trunk; or
- To facilitate healing following an injury to the spine or related soft tissues; or

- To facilitate healing following a surgical procedure on the spine or related soft tissue; or
- To otherwise support weak spinal muscles and/or a deformed spine.

No documentation was received in response to ADR letter.

Suppliers have 45 days from the date of the ADR letter to respond. Failure to respond within 45 days may result in partial or complete denial of the claim.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

No DWO was submitted.

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.

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 and the start date, if start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Physician signature and signature date

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.

Invalid proof of delivery.

The proof of delivery 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. (If utilizing a shipping service or mail order.)
- 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 and date of signature
- Evidence of delivery (If utilizing a shipping service or mail order.)

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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.

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

Coverage Reminder – Osteogenesis Stimulators

Joint DME MAC Publication

A recent examination of Comprehensive Error Rate Testing (CERT) reviews for osteogenesis stimulator claims has identified common errors in the information submitted in support of claims payment. This article will review the findings and related policy requirements.

Reasons for Denial

- Prescriptions
  - Physician's detailed written order is missing, incomplete, or invalid – 25%
- Reasonable & Necessary (R&N)
  - National Coverage Determination (NCD) for osteogenesis stimulators (150.2) coverage criteria for radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with E0747 not met – 53%
- Other
  - Face to Face requirement not met – 6%
  - Missing Certificate of Medical Necessity (CMN) – 3%
  - Unsigned Clinical Notes or use of Signature Stamps – 9%

Payment Rules

Prescriptions:

All items billed to Medicare require a prescription. 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. **Signature and date stamps are not allowed.** Signatures must comply with the CMS signature requirements outlined in PIM 3.3.2.4.

ACA 6407 requires a written order prior to delivery (WOPD) for the HCPCS codes E0747, E0748, and E0760 as specified in the table contained in the Policy Specific Documentation Requirements Section of the Local Coverage Determination (LCD) for Osteogenesis Stimulators. 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.

Face-to-Face Documentation:

ACA 6407 requires face-to-face documentation that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered for the HCPCS codes E0747, E0748, and E0760 as specified in the table contained in the Policy Specific Documentation Requirements Section of the LCD for Osteogenesis Stimulators.

Reasonable and Necessary (R&N) Criteria:

The NCD and LCD for Osteogenesis Stimulators both mandate that coverage for a non-spinal electrical osteogenesis stimulator (E0747) is covered for nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator (criteria 1). Nonunion of a long bone fracture must be documented by a minimum of two sets of radiographs obtained prior to starting treatment with the osteogenesis stimulator, separated by a minimum of 90 days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

Documentation

In the event of a claim review:

- Medicare requires a WOPD.
- Medicare requires Face-to-Face documentation.

- Medicare requires that there be sufficient detailed information contained in the beneficiary's medical record to demonstrate that the relevant policy requirements were met.

This article presents a summary of the policy requirements related to the errors identified in a CERT review. There are additional requirements necessary for coverage that are not discussed in this article. Please refer to the Osteogenesis Stimulator LCD and related Policy article for complete information.

Further education regarding this policy is available on your DME MAC contractor website.

Osteogenesis Stimulators (HCPCS E0747 and E0748) Notification of Service Specific Prepayment Probe Review

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

E0747: OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS

E0748: OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS

Service specific prepayment probe reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on the High Error Rate on a Widespread Probe Review.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes listed above are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for the following specific information to determine if the item billed complies with the existing reasonable and necessary criteria:

- Treating physician's dispensing and written order
- Certificate of Medical Necessity
- Face to face examination with the treating physician, physician assistanct (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) within six months prior to the date of the written order (if applicable)
- Medical records to support the Local Determination Coverage (LCD) policy criteria for the items billed
- Diagnosis codes relating to the specific coverage criteria as indicated in theLCD
- Proof of delivery
- The Advanced Beneficiary Notice (if applicable)
- Any other supporting documentation

Failure to supply the above requested information within 45 days of the date on the letter will result in the claim being denied. Please fax requested documentation and a copy of theADR letterto 1-701-277-7888 or mail to Noridian LLC P.O. Box 6727 Fargo, ND 58108-6727. The ADR letter provided will also provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Osteogenesis Stimulators LCD L11490 and Policy Article A35423.

Additional information, educational opportunities and training tools related to this product category are available on our Training and Events page.

Information about prepay reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

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

PRESSURE REDUCING SUPPORT SURFACES

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0185. The quarterly edit effectiveness results for the E0185 review from September 2014 through November 2014 and the E0181 review from July 2014 through October 2014 are as follows:

The E0185 review involved 248 claims, of which 190 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 77%.

The E0181 review involved 296 claims, of which 177 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 61%.

Top Denial Reasons

- No documentation was received in response to Additional Documentation Request (ADR) letter
- Medical records did not support coverage criteria
- For HCPCS code E0185 documentation did not contain a valid date stamp (or similar)
- Detailed written order (DWO) was incomplete or missing required elements

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Pressure Reducing Support Surfaces –Group 1 Local Coverage Determination (LCD) L11578 and Policy Article A33678.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation was received in response to ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

Medical records did not support coverage criteria.

A group 1 mattress overlay or mattress is covered if one of the following three criteria is met:

- The patient is completely immobile-i.e., patient cannot make changes in body position without assistance, or
- The patient has limited mobility- i.e., patient cannot independently make changes in body position significant enough to alleviate pressure and at least one of conditions A-D below, or
- The patient has any stage pressure ulcer on the trunk or pelvis and at least one of the conditions A-D.

Conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface):

- Impaired nutritional status.
- Fecal or urinary incontinence
- Altered sensory perception
- Compromised circulatory status

For HCPCS code E0185 documentation did not contain a valid date stamp (or similar).

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 written order prior to delivery (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.

The DWO was incomplete or missing required elements.

A detailed WOPD is required for support surfaces. 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.

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 and the start date, if start date is different from the 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, if applicable
- Frequency of use, if applicable
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills or length of need

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).

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.

REFILLS

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

Requirements

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

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

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

Documentation Requirements

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

- There is a change of supplier
- There is a change in the item(s), frequency of use, or amount prescribed

- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

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

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

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

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

Billing Frequencies

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

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

Miscellaneous

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

For additional information, refer to CMS' Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.5 and 5.2.6, and the applicable Local Coverage Determinations and the Supplier Manual.

Claim Status Category and Claim Status Codes

MLN Matters® Number: MM8994
Related Change Request (CR) #: CR 8994
Related CR Release Date: December 5, 2014
Effective Date: April 1, 2015
Related CR Transmittal #: R3143CP
Implementation Date: April 6, 2015

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) 8994 informs MACs about the changes to Claim Status Category Codes and Claim Status Codes. Make sure that your billing staff are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care payers 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 format adopted as the standard for National use under HIPAA. These codes explain the status of submitted claim(s). Proprietary codes may not be used in the ASC X12 276/277 to report claim status. The National Code Maintenance Committee meets at the beginning of each ASC X12 trimester meeting (January, June, and October) and makes decisions about additions of new codes, as well as 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.

These pages have previously been referenced at http://www.wpc-edi.com/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 2015 committee meeting shall be posted on the previously mentioned websites on or about February 1, 2015. MACs must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes by the implementation date of CR 8994.

These code changes are to be used in the editing of all ASC X12 276 transactions processed on or after the date of implementation and are to be reflected in ASC X12 277 transactions issued on and after the date of implementation of CR 8994.

Additional Information

The official instruction, CR 8994 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3143CP.pdf on the CMS website.

Force Balance Claim Payment Reporting on ERA 835 and Cross Over Beneficiary 837 Claim Transactions

MLN Matters® Number: MM9050
Related Change Request (CR) #: CR 9050
Related CR Release Date: February 13, 2015
Effective Date: July 1, 2025
Related CR Transmittal #: R1467OTN
Implementation Date: July 6, 2015

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers that submit 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.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued CR 9050 to alert providers that Claim Adjustment Reason Code (CARC) A7 will be replaced on July 1, 2015, by CARC 121 to report force balancing of Out of Balance (OOB) claims payment/adjudication.

Background

CR9050 modifies the way MACs report force balancing of OOB claim payment/adjudication. Currently, MACs are using CARC A7- Presumptive Payment Adjustment to report the balancing of OOB payments. CR9050 instructs MACs to use CARC 121-Indemnification adjustment- compensation for outstanding member responsibility in place of A7. This will be effective July 1, 2015. In addition, MACs will use Group Code OA (Other Adjustment) as the required Group Code.

Finally, MACs will report offsetting of Veterans Affairs claims at the provider level using PLB code J1 "Non-Reimbursable" and an offsetting dollar amount.

Additional Information

The official instruction for CR9050 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1467OTN.pdf on the CMS website.

RARC, CARC, MREP and PC Print Update

MLN Matters® Number: MM9004
Related Change Request (CR) #: CR 9004
Related CR Release Date: January 9, 2015
Effective Date: April 1, 2015
Related CR Transmittal #: R3161CP
Implementation Date: April 6, 2015

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9004 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists that are effective April 1, 2015. The CR instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes for 2015 and that they obtain the updated MREP or PC Print software if they use that software.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate 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 affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) 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.

SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the on Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9004, MACs will implement on the date specified on the WPC website. The WPC website is available at http://www.wpc-edi.com/Reference on the Internet.

CR9004 lists only the changes that have been approved since the last code update CR (CR8855, Transmittal 2996, issued on July 25, 2014, with a related MLN Matters® article available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8855.pdf), and does not provide a complete list of codes for these two code sets.

The complete list for both CARC and RARC from the WPC website is updated three times a year – around March 1, July 1, and November 1. The WPC website, which has four listings available for both CARC and RARC, is available at http://www.wpc-edi.com/Reference on the Internet.

Changes in CARC List since CR8855

These are changes in the CARC database since the last code update in CR8855.

New Codes – CARC:

Code	Current Narrative	Effective Date
262	Adjustment for delivery cost. Note: To be used for pharmaceuticals only.	11/1/2014
263	Adjustment for shipping cost. Note: To be used for pharmaceuticals only.	11/1/2014
264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.	11/1/2014
265	Adjustment for administrative cost. Note: To be used for pharmaceuticals only.	11/1/2014
266	Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.	11/1/2014
267	Claim spans multiple months. Rebill separate claim/service.	11/1/2014
268	Claim spans 2 calendar years. Please resubmit one claim per calendar year.	11/1/2014

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA). This change effective 11/01/2014: The disposition of this service line is pending further review. (Use only with Group Code OA). NOTE: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).	11/1/2014
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	11/1/2014

Deactivated Codes – CARC –None

Changes in RARC List since CR8855

These are changes in the RARC database since the last code update CR 8855.

New Codes – RARC:

Code	Narrative	Effective Date
N729	Missing patient medical/dental record for this service.	11/1/2014
N730	Incomplete/invalid patient medical/dental record for this service.	11/1/2014
N731	Incomplete/Invalid mental health assessment.	11/1/2014
N732	Services performed at an unlicensed facility are not reimbursable.	11/1/2014
N733	Regulatory surcharges are paid directly to the state.	11/1/2014
N734	The patient is eligible for these medical services only when unable to work or perform normal activities due to an illness or injury.	11/1/2014

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
N42	Missing mental health assessment.	11/1/2014
MA118	Alert: No Medicare payment issued for this claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. Coinsurance and/or deductible are applicable.	11/1/2014
MA09	Claim submitted as unassigned but processed as assigned in accordance with our current assignment/participation agreement.	11/1/2014

Deactivated Codes – RARC

Code	Current Narrative	Effective Date
N483	Missing Periodontal Charts	05/1/2015
N484	Incomplete/invalid Periodontal Charts.	5/1/2015

In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version should be implemented.

Additional Information

The official instruction, CR9004, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3161CP.pdf on the CMS website.

Payment Repairs to Capped Rental Equipment Prior to the End of the 13-Month Cap

MLN Matters® Number: MM 9062
Related Change Request (CR) #: CR 9062
Related CR Release Date: February 13, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R203BP and R3196CP
Implementation Date: July 6, 2015

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9062 alerts suppliers and DME MACs that reasonable and necessary charges for maintenance and servicing of beneficiary-owned DME will be made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty and where the supplier transfers title to the beneficiary prior to the end of the 13 month period of continuous use. CR9062 supplements CR7212 that did not account for situations in which the title of the item is transferred to the beneficiary prior to the end of the 13 month rental period. Make sure your billing staffs are aware of these changes.

Background

CR9062 instructs the DME MACs to ensure editing occurs on all payments for reasonable and necessary maintenance and servicing of capped rental items in cases where one or more rental payments have been made for a capped rental item and the supplier transfers the title to the equipment to the beneficiary prior to the end of a 13 month period of continuous use.

Transmittal 901, CR7212 issued on May 27, 2011 "Edit to Deny Claims for Repairs to Capped Rental Durable Medical Equipment (DME)" established billing procedures for payment for all maintenance, servicing and repairs of capped rental DME included in the allowed rental payment amounts. For equipment furnished on a rental basis no separate payment may be made for these services prior to the end of the 13-month capped rental period.

Medicare payment can be made for repairs of the equipment after the transfer of title if the DME MAC determines that the repairs are reasonable and necessary in accordance with Medicare regulations and program instructions.

Key Points of CR9062

Your DME MAC will:

- Process claims for replacement parts furnished in conjunction with the repair of a capped rental items that are billed with the RB modifier, including claims for the parts that are billed during the capped rental period if there is evidence that the supplier has transferred the title of the capped rental item to the beneficiary;
- Process and pay claims for reasonable and necessary repairs that are billed with the HCPCS code K0739 for the labor associated with the repairs to capped rentals items if there is evidence that the supplier has transferred the title of the capped rental item to the beneficiary.

Note: An attestation of warranty transfer (be it a copy of the warranty or a signed/dated statement from the beneficiary verifying transfer) must be kept on file at the supplier submitting the claim, and available to be submitted upon request.

In cases where one or more monthly rental payments have been made in accordance with 42 CFR 414.229 for a capped rental DME item, medical necessity for the equipment has been established. In cases where one or more rental payments have been made for an item classified as capped rental DME, and the supplier transfers the title of the equipment prior to the end of a 13 month period of continuous use per 42 CFR 414.230, Medicare payment is made for reasonable and necessary maintenance and servicing of the beneficiary-owned DME.

Under the regulations at 42 CFR 414.210(e)(1), reasonable and necessary charges for maintenance and servicing are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty. Charges for routine maintenance and servicing would not be covered. Charges for maintenance and servicing that exceed the purchase price of the equipment (i.e., the capped rental monthly fee multiplied by 10) would not be reasonable and necessary and should be denied.

In the case of a manufacturer or supplier warranty, if the DME MAC can confirm that the manufacturer or supplier is no longer in business and the warranty that the manufacturer or supplier previously offered is no longer in effect for the item of capped rental equipment, DME MACs will allow the charges for replacement parts and labor related to maintenance and servicing of beneficiary-owned equipment, if otherwise reasonable and necessary, in accordance with the above requirements.

In the case of a manufacturer or supplier warranty, if the DME MAC can confirm that the manufacturer or supplier is still in business and there is a warranty in effect for the capped rental item, then the DME MAC will deny claims for replacement parts and labor furnished in conjunction with the repair of a capped rental item. Your DME MAC will use the following group code and messages, when denying claims for replacement parts and labor:

- **Group Code – Contractual Obligation (CO) 97:** The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. NOTE: refer to the 835 healthcare policy identification segment (loop 2110 service payment information ref), if present.
- **MA 13: Alert:** You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
- **N211 Alert:** You may not appeal this decision.

In addition, the DME MACs will close the Certificate of Medical Necessity (CMN) as a purchase when there is evidence that the supplier has transferred the title of a capped rental item to a beneficiary.

Additional Information

CR9062 consists of two transmittals. The first updates the "Medicare Benefit Policy Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R203BP.pdf on the CMS website. The second updated the "Medicare Claims Processing Manual" and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3196CP.pdf on the CMS website.

To review MM7212 Edit to Deny Claims for Repairs to Capped Rental Durable Medical Equipment (DME) go to: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7212.pdf on the CMS website.

Continuous Positive Airway Devices (HCPCS E0601) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0601for the first month of billing and the 4 - 13 months of billing. The quarterly edit effectiveness results from July 2014 through October 2014 are as follows:

The E0601 first month of billing review involved 3211 claims, of which 1810 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 53%.

The E0601 4 - 13 months of billing review involved 1666 claims, of which 943 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 59%.

Top Denial Reasons

- No documentation of a valid date stamp or similar for Written Order Prior to Delivery (WOPD)
- Documentation submitted did not support criterion two (objective evidence of adherence) was met for continued coverage beyond the first three months for (KJ) claims
- No documentation was received in response to Additional Documentation Request (ADR) letters
- Criterion 1 for continued coverage beyond the first three months for (KJ) claims is not met

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure (PAP) Devices Local Coverage Determination (LCD) L171 and Policy Article A19827.

Suppliers can also review a specific policy Documentation Checklist for PAP Devices on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation of a valid date stamp or similar for WOPD.

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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier's possession BEFORE the item is delivered.

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.

Documentation submitted did not support criterion two (objective evidence of adherence) was met for continued coverage beyond the first three months for (KJ) claims.

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

For PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

- Objective evidence of adherence to use of the PAP device, reviewed by the treating physician. Adherence to therapy is defined as use of PAP ≥4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

No documentation was received in response to ADR letters.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the request documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on the Noridian Medicare website.

Criterion one for continued coverage beyond the first three months for (KJ) claims is not met.

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

For PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

- Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved.

If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the beneficiary is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

Correct Coding – Integrated Respiratory Products

Joint DME MAC Publication

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have recently had multiple inquiries about the coding of products where multiple functions, each with a separate HCPCS code, are incorporated into a single product. For example, there are positive airway pressure (PAP) and respiratory assist devices (RAD) that include integrated humidification. The correct codes for the integrated product are code E0601 (Continuous positive airway pressure (CPAP) device) for the base CPAP device and code E0562 (Humidifier, heated, used with positive airway pressure device) for the integrated humidification. The same principle applies to respiratory assist devices with integrated humidification. The correct codes for the integrated RAD products are code E0470 (Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device), or E0471 (Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device) for the base RAD device and code E0562 for the integrated humidification.

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.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0439 and E0434. The quarterly edit effectiveness results from July 2014 through October 2014 are as follows:

The E0439 review involved 153 claims, of which 119 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 77%.

The E0434 review involved 104 claims, of which 81 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 66%.

Top Denial Reasons

- No documentation of valid date stamp or similar for Written Order Prior to Delivery (WOPD)
- No documentation of valid WOPD
- The proof of delivery (POD) submitted is invalid
- No documentation was received in response to Additional Documentation Request (ADR) letter

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) and Policy Article.

Suppliers can also review a specific policy Documentation Checklist for Oxygen and Oxygen Equipment on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation of a valid date stamp or similar for WOPD.

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.

No documentation of a valid WOPD.

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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier's possession BEFORE the item is delivered.

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 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 Identifier (NPI)

- The signature of the ordering practitioner
- Signature date

The POD submitted is invalid.

PROOF OF DELIVERY (PIM 4.26, 5.8)

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 Office of Inspector General (OIG) for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. There are two methods of delivery:

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service

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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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 record must contain the information specified above.

No documentation was received in response to ADR letters.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the request documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on the Noridian Medicare website.

Respiratory Assist Device (HCPCS E0470) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0470. The quarterly edit effectiveness results from July 2014 through October 2014 are as follows:

The E0470 review involved 39 claims, of which 29 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 75%.

Top Denial Reasons

- No documentation of a valid date stamp or similar for Written Order Prior to Delivery (WOPD)
- No documentation received of face-to-face clinical evaluation prior to the sleep test
- No documentation received of a diagnostic sleep test (PSG) that meets Medicare coverage criteria
- No/Invalid documentation to support a new initial face-to-face clinical evaluation for a beneficiary who switched to an E0470 after greater than three months use of E0601

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Positive Airway Pressure Devices (PAP) Local Coverage Determination (LCD) L171 and Policy Article 19827.

Suppliers can also review a specific policy Documentation Checklist for Positive Airway Pressure Devices on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

No documentation of a valid date stamp or similar for WOPD.

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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier's possession BEFORE the item is delivered.

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.

No documentation received of face-to-face clinical evaluation prior to sleep test.

There must be documentation to support that the beneficiary has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

No documentation received of a PSG that meets Medicare coverage criteria.

The beneficiary has a sleep test (as defined below) that meets either of the following criteria (1 or 2):

- The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
- The AHI or RDI is greater than or equal to five and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
  - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
  - Hypertension, ischemic heart disease, or history of stroke.

Apnea is defined as the cessation of airflow for at least 10 seconds.

Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds associated with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation.

The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device. For purposes of this policy, respiratory effort related arousals (RERAs) are not included in the calculation of the AHI. Sleep time can only be measured in a Type I (facility based polysomnogram) or Type II sleep study (see descriptions below).

The respiratory disturbance index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device. For purposes of this policy, respiratory effort related arousals (RERAs) are not included in the calculation of the RDI. The RDI is reported in Type III, Type IV, and Other home sleep studies.

If the AHI or RDI is calculated based on less than two hours of sleep or recording time, the total number of recorded events used to calculate the AHI or RDI (respectively) must be at least the number of events that would have been required in a two hour period (i.e., must reach ≥30 events without symptoms or ≥10 events with symptoms).

No/Invalid documentation to support a new initial face-to-face clinical evaluation for a beneficiary who switched to an E0470 after greater than three months use of E0601.

If an E0601 device has been used for more than three months and the beneficiary is switched to an E0470, a new initial face-to-face clinical evaluation is required, but a new sleep test is not required. A new three month trial would begin for use of the E0470.

Correct Billing of Non-Invasive Interfaces Used in Conjunction with HCPCS Code E0472

Joint DME MAC Article

Recently during claims review it was noted that suppliers are billing HCPCS code E0472 (RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACKUP RATE FEATURE, USED WITH INVASIVE INTERFACE, E.G., TRACHEOSTOMY TUBE (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)) with non-invasive interfaces. This is not correct billing. As noted in the code descriptor, code E0472 is reserved for devices used with an invasive interface. Claims for E0472 must not be billed with any of the following non-invasive interfaces or accessories:

A7027 - COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH

A7028 - ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH

A7029 - NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR

A7030 - FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH

A7031 - FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH

A7032 - CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH

A7033 - PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, PAIR

A7034 - NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP

A7035 - HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE

A7036 - CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE

A7044 - ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH

Claims for devices used with a non-invasive interface are billed with HCPCS codes E0470 or E0471, depending on whether or not the device has a backup rate feature.

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.

Oxygen (HCPCS E1390) Quarterly Results of Documentation Compliance Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a documentation compliance review of HCPCS code E1390, oxygen concentrator. A documentation compliance review is a nonclinical, technical review verifying that submitted documentation meets payment requirements according to Local Coverage Determinations (LCD) for that DMEPOS item. The quarterly edit effectiveness, from September 1 through November 30, 2014, resulted in an overall error rate of 21%.

Top Denial Reasons

- There was no proof of delivery (POD) submitted or the POD was invalid.
- There was no documentation to support the beneficiary had been seen and evaluated by the treating physician within 30 days prior to the date of the initial Certificate of Medical Necessity (CMN).
- Requested documentation was not received by the contractor within the allotted timeframe.
- The documentation provided did not contain the beneficiary's most recent arterial blood gas P02 and/or oxygen saturation test.

Going Forward

Based on the results of this review, Noridian will continue with the Documentation Compliance Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L11457 and Policy Article A33677.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

There was POD submitted or the POD was invalid.

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4 and 5, Section 4.26 and 5.8 states that:

> 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 durable medical equipment 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 Office of Inspector General (OIG) for imposition of Civil Monetary Penalties or other administrative sanctions.

Suppliers are required to maintain POD documentation in their files. There are three methods of delivery:

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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. 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 record 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.

There was no documentation to support the beneficiary had been seen and evaluated by the treating physician within 30 days prior to the date of the initial CMN.

LCD L11457 Testing and Visit Requirements states that an evaluation by the treating physician, within 30 days prior to initial certification, is required when the CMN is initiated in the following instances:

- With the first claim for home oxygen, (even if the beneficiary was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare Health Maintenance Organization (HMO).)
- During the first 36 months of the rental period, when there has been a change in the beneficiary's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. (Please refer to the Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES for additional information.)

Documentation not received within the correct time frame.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). 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 patient's medical records will reflect the need for the care provided. The patient'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.

The documentation provided did not contain the beneficiary's most recent arterial blood gas P02 and/or oxygen saturation test.

LCD L11457 indicates the qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. These prohibitions do not extend to blood gas studies performed by a hospital certified to do such tests.

The qualifying blood gas study may be performed while the beneficiary is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.

When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met. If an ABG test done at rest and awake is nonqualifying, but either an exercise or sleep oximetry test on the same day is qualifying, the exercise or oximetry test result will determine coverage.

All oxygen qualification testing must be performed in-person by a physician or other medical professional qualified to conduct oximetry testing. With the exception of overnight oximetry (see below), unsupervised or remotely supervised home testing does not qualify as a valid test for purposes of Medicare reimbursement of home oxygen and oxygen equipment.

Claims for oxygen equipment and supplies for beneficiaries who do not meet the coverage requirements for home oxygen therapy will be denied as not reasonable and necessary.

SURGICAL DRESSINGS

Correct Coding – Surgical Dressings Containing Non-Covered Components

DME MAC Joint Publication

Some surgical dressings are produced containing non-covered components. This article reviews the coding guidelines for these items. The Surgical Dressings Local Coverage Determination (LCD) related Policy Article (PA) states:

> "Products containing multiple materials are categorized according to the clinically predominant component (e.g., alginate, collagen, foam, gauze, hydrocolloid, hydrogel). Other multi-component wound dressings not containing these specified components may be classified as composite or specialty absorptive dressings if the definition of these categories has been met. Multi-component products may not be unbundled and billed as the separate components of the dressing." (PA Coding Guidelines)

Historically, non-covered components have not been the majority constituent in multicomponent products. Recently, dressings where the non-covered components comprise the majority of the dressing have been identified.

The coding guideline for multi-component dressings states that the clinically predominant component will determine classification. Following this guideline:

- Dressings only containing non-covered components, with or without a substrate, are coded as A9270 (Non-covered item or service)
- Multicomponent dressings are coded based upon the clinically predominant component. For dressings that contain non-covered elements:
  - If the non-covered components are less than 50% of the dressing, coding is determined by the predominant covered component.
  - If the non-covered components comprise 50% or more of the dressing, the dressing is assigned to code A9270 (non-covered item or service).

SURGINCAL DRESSINGS

Refer to the Surgical Dressing LCD and related PA for additional information about coding and coverage.

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/.

TENS

Conductive Garment for Delivery of TENS or NMES (HCPCS E0731) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0731. The final edit effectiveness results from August 2014 through December 2014 are as follows:

> The E0731 review involved 62 claims, of which 60 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 98%.

Top Denial Reasons

- There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.
- The detailed written order did not contain the practitioner's National Provider Identifier (NPI) number.
- The documentation did not contain a valid date stamp or similar.
- The order was not dated.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Suppliers can also review specific policy resources for Transcutaneous Electrical Nerve Stimulators on the Noridian website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

There was no documentation submitted in response to the ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section of the Noridian Medicare website.

The detailed written order did not contain the practitioner's NPI number.

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.

The documentation did not contain a valid date stamp or similar or the order was not dated.

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

Someone other than the ordering physician may produce the WOPD. 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 and the start date, if the start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Prescribing physician's National Provider Identifier (NPI) (*Note that only individual NPI numbers must be used. Institutional or group NPI numbers are not acceptable)
- 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

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.

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.

The supplier must have the properly authenticated WOPD in their files before the item is dispensed. Suppliers must document the date that the WOPD was received using a date stamp or similar indicator.

The WOPD must be available upon request.

TENS (HCPCS E0730) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code E0730. The final edit effectiveness results from August 2014 through December 2014 are as follows:

> The E0730 review involved 195 claims, of which 187 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 98%.

Top Denial Reasons

- There was no documentation submitted to support usage and frequency.
- There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.
- The proof of delivery was invalid.
- The documentation did not contain a valid date stamp or similar.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Transcutaneous Electrical Nerve Stimulators (TENS) Local Coverage Determination (LCD) L11495 and Policy Article A37074.

Suppliers can also review specific policy resources for TENS on the Noridian Medicare website. There, you will find information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during web-based workshops.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

There was no documentation submitted to support usage and frequency.

For chronic pain other than low back pain, there must be information in the medical record describing the re-evaluation of the beneficiary at the end of the trial period. It must indicate the following:

- How often the beneficiary used the TENS unit
- The typical duration of use each time
- The results (effectiveness of therapy)

There was no documentation submitted in response to the ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on the Noridian Medicare website.

The proof of delivery was invalid.

For Transcutaneous Electrical Nerve Stimulators, there are two methods of delivery:

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 slip. The POD record 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 and date of signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the beneficiary or designee. In instances where the supplies are delivered directly by the supplier, the date the beneficiary received the DMEPOS item 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 record must contain the information specified above.

The documentation did not contain a valid date stamp or similar.

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

Someone other than the ordering physician may produce the WOPD. 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 and the start date, if the start date is different from the date of the order
- Detailed description of the item(s) (see below for specific requirements for selected items)
- Prescribing physician's National Provider Identifier (NPI) (*Note that only individual NPI numbers must be used. Institutional or group NPI numbers are not acceptable)
- 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

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.

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.

The supplier must have the properly authenticated WOPD in their files before the item is dispensed. Suppliers must document the date that the WOPD was received using a date stamp or similar indicator.

The WOPD must be available upon request.

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

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code A5500. The quarterly edit effectiveness results from September 2014 through December 2014 are as follows:

> The A5500 review involved 2,798 claims, of which 2,190 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 78%.

Top Denial Reasons

- Documentation of foot abnormalities by certifying physician not met
- Documentation of diabetes management by certifying physician is not met
- No documentation was received in response to Additional Documentation Request (ADR) letter
- Documentation of in-person visit prior to selection of items not met

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes Local Coverage Determination (LCD) L157 and Policy Article A37076.

Suppliers can also review a specific policy Documentation Checklist for Therapeutic Shoes on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation of foot abnormalities by certifying physician not met.

There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

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

In order to meet criterion 2, the certifying physician must either:

- Personally document one or more of criteria a – f in the medical record of an in-person visit within six months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or
- Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other doctor of medicine (M.D.) or doctor of osteopathy (D.O.), physician assistant, nurse practitioner, or clinical nurse specialist that is within six months prior to delivery of the shoes/inserts, and that documents one of more of criteria above.

Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

Documentation of diabetes management by certifying physician not met.

There must be documentation to support that the certifying physician has certified that indications (1) and (2) are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes. For claims with dates of service on or after January 1, 2011, the certifying physician must:

- Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
- Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

Note: Per Policy Article A37076 the Certifying Physician is defined as an M.D. or D.O. who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

No documentation was received in response to ADR letter.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R §424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on our website.

Documentation of in-person visit prior to selection of items not met.

There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

- An examination of the patient's feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
- For all shoes, taking measurements of the patient's feet.

For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient's feet that will be used in creating positive models of the feet.

Vacuum Erection Devices (HCPCS L7900) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS code L7900. The quarterly edit effectiveness results from September 2014 through November 2014 are as follows:

> The L7900 review involved 413 claims, of which 280 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 69%.

Top Denial Reasons

- The documentation did not support the medical necessity of the item ordered.
- The documentation did not support an in-person clinical evaluation with their treating physician within six (6) months prior to ordering the Vacuum Erection Device (VED).
- The documentation did not support that the beneficiary has no evidence of symptomatic or untreated hypogonadism or hyperprolactinemia.
- The documentation did not support other treatment options have been tried or considered and ruled out, and the result (if tried) or contraindication (if considered) must be clearly documented in the beneficiary's medical record.
- There was no documentation submitted in response to the Additional Documentation Request (ADR) letter.

Going Forward

Based on the results of this review, Noridian will continue with the Prepayment Service Specific Review.

Educational Resources

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the following:

- National Coverage Determination (NCD) for Diagnosis and Treatment of Impotence NDC 230.4
- CMS Publication 100-8
- Program Integrity Manual (PIM) Chapter 5
- Supplier Manual Chapter 3.
- For services performed on or after August 1, 2014 the Vacuum Erection Devices Local Coverage Determination (LCD) L34736 and Policy Article A52677.

Suppliers can also review a specific policy Documentation Checklist for Vacuum Erection Devices on the Noridian website.

Noridian provides educational offerings by scheduling supplier workshops, training opportunities, and presentations.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

Policy Education

Documentation did not support medical necessity.

The Program Integrity Manual chapter 5 section 5.7 states, "For any DMEPOS item to be covered by Medicare, the beneficiary's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity off items ordered and for the frequency of use or replacement (if applicable). The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary'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. There must be information in the beneficiary's medical record that supports the medical necessity for the item and substantiates the answers on the Cerficate of Medical Necessity (CMN) (if applicable) or DME Information Form (DIF) (if applicable) or information on a supplier prepared statement or physician attestation (if applicable)".

For services performed on or after August 1, 2014:

A vacuum erection device (L7900) and tension ring (L7902) are covered for the treatment of erectile dysfunction (ED) secondary to organic impotence (see Diagnosis Codes section in related Policy Article) if all of criteria 1-3 are met:

- The beneficiary has an in-person clinical evaluation with their treating physician within six (6) months prior to ordering the VED; and,
- The beneficiary has no evidence of symptomatic or untreated hypogonadism or hyperprolactinemia and,
- Other treatment options have been tried or considered and ruled out, and the result (if tried) or contraindication (if considered) must be clearly documented in the beneficiary's medical record.

If any of criteria 1 - 3 are not met, L7900 and related supplies (L7902) will be denied as not medically necessary.

The physician ordering the VED and related supplies must be a physician treating the beneficiary for the disease or condition justifying the need for the VED.

Vacuum erection devices and related supplies will be denied as non-covered in situations involving temporary impairments.

Policy Specific Documentation Requirements

For criteria 1 and 2 in the Coverage Indications, Limitations, and/or Medical Necessity section, the physician must document in the medical record a beneficiary's sexual, medical and psychosocial history. This in-person clinical evaluation must include a physical examination focused on an assessment of the genitourinary, endocrine, vascular and neurologic systems and include, at a minimum, a genital and rectal examination, to rule out reversible causes of ED.

For criterion 3 in the Coverage Indications, Limitations, and/or Medical Necessity section, the medical record must address the following alternative treatment options:

- If clinically appropriate, modification or discontinuation of medications contributing to ED (e.g., anti-hypertensives, anti-depressants, anxiolytics, etc.);
- The use of phosphodiesterase type 5 (PDE-5) inhibitors, intracavernous injections or intraurethral prostaglandins.

VACUUM ERECTION DEVICES

No documentation was received in response to ADR letters.

Suppliers are in violation of Supplier Standard #28 when, upon request, they fail to provide requested documentation to a Medicare contractor. Medicare regulations (42 C.F.R 424.516[f]) stipulate that a supplier is required to maintain documentation for seven years from the date of service and, upon the request of CMS or a Medicare contractor, provide access to that documentation. Therefore, the consequences of failure to provide records may not only be a claim denial but also referral to the National Supplier Clearinghouse (NSC). The supplier standards can be found in 424 CFR Section 424.57(c).

Please also remember, the documentation must be submitted to our office within 45 days from the date on the ADR letter. Failure to provide the requested documentation within 45 days may result in a partial or complete denial of the claim. Submission information can be found on the ADR letters or under the claims section on the Noridian Medicare website.

VENTILATORS

Pressure Support Ventilators (HCPCS E0464) Notification of Service Specific Prepayment Probe Review

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

> **E0464: Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface (e.g., mask)**

Service specific prepayment probe reviews are used to determine the extent of potential problem areas across multiple suppliers. This review is being initiated based on data analysis findings related to billing patterns.

In order to evaluate compliance with Medicare coverage and coding rules, all suppliers billing Jurisdiction D for HCPCS codes listed above are subject to this review. Suppliers of the selected claims will receive an Additional Documentation Request (ADR) letter asking for the following specific information to determine if the item billed complies with the existing reasonable and necessary criteria:

- Treating physician's written order prior to delivery including the prescribing physician's National Provider Identifier (NPI)
- Documentation to support the beneficiary had a face-to-face examination with the physician, Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) within six months prior to the date of the written order (if applicable)
- Treating physician must sign/co-sign the face-to-face encounter of the PA, NP, or CNS (if applicable)
- Patient's medical records (physician medical records, hospital records, nursing home records, home care nursing notes, physical/occupational therapy notes) to support the patient is being treated for one of the following conditions: neuromuscular diseases, thoracic restrictive diseases, or chronic respiratory failure consequent to chronic obstructive pulmonary disease.
- Proof of delivery
- The Advanced Beneficiary Notice of Noncoverage (ABN) (if applicable)
- Any other supporting documentation

Failure to supply the above requested information within 45 days of the date on the letter will result in the claim being denied. Please fax requested documentation and a copy of the ADR letter to 1-701-277-7888 or mail to Noridian LLC P.O. Box 6727 Fargo, ND 58108-6727. The ADR letter provided will also provide instruction for submitting documentation.

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Internet only manual, Pub. 100-3 Chapter 1, Part 4, Section 280.1 and the DME MAC Jurisdiction D Online Supplier Manual.

Additional information, educational opportunities and training tools related to this product category are available on our Training and Events page.

Information about prepay reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3.

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