DME Happenings

Jurisdiction D

Issue No. 47
May 2015

In This Issue...

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

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noridian
Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Noridian Healthcare Solutions, LLC

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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

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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
8 a.m. – 6 p.m. CT	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
Off-the-Phone Training	August 28, 2015	9:40 a.m. – 12 p.m. CT

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Event	Date	Closure Timeframe
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
8 a.m. – 6 p.m. CT	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
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
Off-the-Phone Training	July 10, 2015	9:30 a.m. – 12 p.m. CT

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Event	Date	Closure Timeframe
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

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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

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comprehensive resource is published by CMS on the first business day of each quarter. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for "Jurisdiction D Happenings" Articles

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

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

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	Change Date
Chapter 13	Reopenings	Updated phone number	03/02/15

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Chapter	Subheading	Supplier Manual	Change Date
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
3	Medicare HMO Beneficiaries Transferring to Fee-for-service Medicare	Added a new paragraph	01/21/15
9	General Medical Policy Information	Adjusted the outline layout	01/21/15
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 the section.	01/21/15
17	Medicare Remit Easy Print	Update CMS website link	01/21/15

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APPEALS

Telephone Reopenings: Resources for Success

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

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

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

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-888-826-5708.
What are the hours for Telephone Reopenings?	Monday through Friday 8 a.m. - 4:30 p.m. CT Further closing information can be found at https://med.noridianmedicare.com/web/jddme/contact/holiday-schedule

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

What may I request as a Telephone Reopening?	The following is a list of clerical errors and omissions that may be completed as a Telephone Reopening. Note: This list is not all-inclusive.
	• Diagnosis code changes or additions
	• Date of Service (DOS) changes
	• HCPCS code changes
	• Certain modifier changes or additions (not an all-inclusive list)
	  • KH
	  • 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.

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

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

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APPEALS

How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-888-826-5708.
What do I do when I have a large amount of corrections?	• If a supplier has more than 50 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information and provide further direction how to submit the request • If a supplier has a least 10 DOS, the supplier can request a phone appointment for a 30 minute interval. A Telephone Reopenings representative will call the supplier at the designated time and will complete as many reopenings as possible in that time.
Where can I find more information on Telephone Reopenings?	• Supplier Manual Chapter 13 • Appeals Section on the Noridian DME website • IOM Publication 100-04, Chapter 34
Additional assistance available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Please note, emails containing Protected Health Information (PHI) will be returned as unprocessable.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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CERT

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.

CMS MLN CONNECTS ENEWS

MLN Connects Provider eNews - March 5, 2015

MLN Connects® Provider eNews for March 5, 2015

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In This Edition:

MLN Connects® National Provider Calls

- National Partnership to Improve Dementia Care in Nursing Homes and QAPI — Last Chance to Register
- Physician Quality Reporting Programs: Reporting Once in 2015 — Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript
- Providers and Suppliers — Browse the MLN Connects® Call Program Collection of Resources

CMS Events

- Special Open Door Forum: Home Health Electronic Clinical Template and Home Health Paper Clinical Template

Announcements

- Help Your Medicare Patients "Bite into a Healthy Lifestyle" During National Nutrition Month® and Beyond
- Physician Groups that Demonstrate High Quality Care Receive Increases to Their Medicare Payments
- CMS Announces Release of 2015 Impact Assessment of Quality Measures Report
- Register for the Health Care Payment Learning and Action Network
- New EHR Attestation Deadline for Medicare Eligible Professionals: March 20
- Submission Extension for EPs Participating in PQRS via EHR and QCDR: March 20
- Hospital VBP FY 2017 Baseline Measures Report Now Available
- HHAs: Get Started with HHCAHPS Participation
- Request for Comments on ESRD Conditions for Coverage
- Physicians and Teaching Hospitals: Register in Open Payments System
- PQRS Payment Adjustments and Providers Who Rendered Services at IDTFs
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Special CBSA Codes for Home Health Claims
- FQHC Prospective Payment System File Update

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Medicare Learning Network® Educational Products

- "Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program – Overview & Implementation" MLN Matters® Article — Released
- "Diagnosis Coding: Using the ICD-10-CM" Web-Based Training Course — Released
- "Medicare Physician Fee Schedule" Fact Sheet — Revised
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet — Reminder
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet — Reminder
- New Medicare Learning Network® Provider Compliance Fast Fact
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects Provider eNews - March 12, 2015

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MLN Connects® National Provider Calls

- Physician Quality Reporting Programs: Reporting Once in 2015 — Last Chance to Register
- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 — Registration Now Open
- Medicare Shared Savings Program ACO: Application Process — Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- ICD-10 Coordination and Maintenance Committee Meeting
- Webinar for Comparative Billing Report on Modifier 25: Nurse Practitioners

Announcements

- Affordable Care Act Initiative Builds on Success of ACOs
- Physician-owned Hospital Initial Annual Ownership/Investment Report: Extension of Filing Deadline
- New ST PEPPER Available
- Medicare EHR Incentive Program: Hardship Exceptions for Hospitals due April 1
- EHR Incentive Program: Part B Drugs and Payment Adjustments

Claims, Pricers, and Codes

- April 2015 Average Sales Price Files Now Available
- FY 2015 Inpatient PPS PC Pricer Update Available
- FY 2014 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Guidance on the Physician Quality Reporting System (PQRS) 2013 Reporting Year and 2015 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)" MLN Matters® Article — Released
- "Global Surgery" Fact Sheet — Revised
- "Guidelines for Teaching Physicians, Interns, and Residents" Fact Sheet — Revised
- "Mental Health Services" Booklet — Revised

RETIRED

- "Medicare Vision Services" Fact Sheet — Reminder
- "HIPAA Privacy and Security Basics for Providers" Fact Sheet — Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects Provider eNews - March 19, 2015

MLN Connects® Provider eNews for March 19, 2015

View this edition as a PDF

In This Edition:

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 — Register Now
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data — Registration Opening Soon
- Medicare Shared Savings Program ACO: Application Process — Register Now

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July — Forms Due April 17
- eHealth Webinar: eCQM 101 on Quality Reporting Programs
- Medicare Basics for New Providers Webinar — Registration Now Open

Announcements

- Prepare for a Successful Transition to ICD-10 with Medicare Testing Resources
- RAs from January 2015 ICD-10 End-to-End Testing
- Bidding for Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program Closes March 25
- March is National Colorectal Cancer Awareness Month—Encourage Your Patients to Get Screened
- March is Save Your Vision Month
- Flu on the Decline but Still Active
- EHR Incentive Program: Eligible Professionals Attest for 2014 Participation by March 20
- CMS Extends Letter of Intent Deadlines for the Oncology Care Model
- Obtaining Your Quality and Resource Use Report: Updated Information Available
- CMS to Release Ophthalmology Comparative Billing Report in April
- Physician-owned Hospital Initial Annual Ownership/Investment Report: Extension of Filing Deadline

Claims, Pricers, and Codes

- Mandatory Payment Adjustment Percentage of 2% Extended for Medicare FFS Claims (Sequestration)
- Correcting the Display Issue for OPPS Claims Where Value Code "FD" Is Present
- Mass Adjustment of Claims Containing Codes G0473 and 77063

Medicare Learning Network® Educational Products

- March 2015 Version of The Medicare Learning Network® Catalog — Released

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MLN Connects Provider eNews - March 24, 2015

Attention Health Professionals: Information Regarding the 2015 Medicare Physician Fee Schedule

The negative update of 21% under current law for the Medicare Physician Fee Schedule is scheduled to take effect on April 1, 2015. Medicare Physician Fee Schedule claims for services rendered on or before March 31, 2015, are unaffected by the payment cut and will be processed and paid under normal procedures and time frames. The Administration urges Congress to take action to ensure these cuts do not take effect. However, until that happens, CMS must take steps to implement the negative update. Under current law, electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt. CMS will notify you on or before April 11, 2015, with more information about the status of Congressional action to avert the negative update and next steps.

MLN Connects Provider eNews - March 26, 2015

MLN Connects® Provider eNews for March 26, 2015

View this edition as a PDF

In This Edition:

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 — Register Now
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data — Registration Now Open
- How to Register for the PQRS Group Practice Reporting Option in 2015 — Registration Now Open
- Medicare Shared Savings Program ACO: Application Process — Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July — Forms Due April 17
- Medicare Basics for New Providers Webinar — Register Now

Announcements

- DOJ and HHS Announce over $27.8 Billion in Returns from Joint Efforts to Combat Health Care Fraud
- HHS Announces Proposed Rules to Support the Path to Nationwide Interoperability
- Star Ratings for Home Health Compare: Provider Preview Reports Available in Late March
- Medicare EHR Incentive Program Hospitals: Apply for Hardship Exception by April 1

Claims, Pricers, and Codes

- New RARC Alerts Providers about Upcoming Transition to ICD-10
- Updates to IRIS Software
- FY 2015 Inpatient PPS PC Pricer Update Available

Medicare Learning Network® Educational Products

- "Safeguard Your Identity and Privacy Using PECOS" Fact Sheet — Reminder
- "Internet-based PECOS FAQs" Fact Sheet — Reminder
- Medicare Learning Network® Product Available In Electronic Publication Format

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MLN Connects Provider eNews – April 2, 2015

MLN Connects® Provider eNews for April 2, 2015

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In This Edition:

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Preparing to Apply for 2016 — Last Chance to Register
- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data — Register Now
- How to Register for the PQRS Group Practice Reporting Option in 2015 — Register Now
- Medicare Shared Savings Program ACO: Application Process — Register Now
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July — Forms Due April 17

Announcements

- Screening and Counseling to Reduce Alcohol Misuse
- Newly Approved Drugs and Biologicals
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Register for the Health Care Payment Learning and Action Network
- Quarterly Provider Update for April 2015
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Modifications to HCPCS Code Set
- Partial Hospitalization Program Claims Coding and Payment Rates for CY 2015
- New RARC Alerts Providers about Upcoming Transition to ICD-10

Medicare Learning Network® Educational Products

- "Preventive Services" Educational Tool — Revised
- "Long Term Care Hospital Prospective Payment System" Fact Sheet — Revised
- "Clinical Laboratory Fee Schedule" Fact Sheet — Revised
- "Medicare Appeals Process" Fact Sheet — Reminder
- "Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians" Fact Sheet — Reminder
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects Provider eNews – April 9, 2015

MLN Connects® Provider eNews for April 9, 2015

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In This Edition:

MLN Connects® National Provider Calls

- Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data — Last Chance to Register
- How to Register for the PQRS Group Practice Reporting Option in 2015 — Last Chance to Register
- Medicare Shared Savings Program ACO: Application Process — Register Now

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July — Forms Due April 17
- Webinar for Comparative Billing Report on Ophthalmology

Announcements

- Results From March 2015 ICD-10 Acknowledgement Testing Week
- Prepare for a Successful Transition to ICD-10 with Medicare Testing Resources
- 2015 PV-PQRS GPRO Registration is Now Open
- Open Payments Physician and Teaching Hospital Review and Dispute Period Began April 6
- EHR Stage 3 Proposed Rule: Comment Period Closes May 29
- Medscape Article for CME Credit: Public Reporting on Quality and Payments

Claims, Pricers, and Codes

- Mass Adjustment of OPPS Claims with APC 1448
- April 2015 Outpatient Prospective Payment System Pricer File Update
- January 2015 PPS Provider Data Available — Revised

Medicare Learning Network® Educational Products

- "Food and Drug Administration Approval of First Biosimilar Product" MLN Matters® Article — Released
- "Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014" MLN Matters® Article — Released
- "Partial Hospitalization Program (PHP) Claims Coding & CY2015 per Diem Payment Rates" MLN Matters® Article — Released
- "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants" Booklet — Revised
- "The ABCs of the Initial Preventive Physical Examination (IPPE)" Educational Tool — Revised
- "The ABCs of the Annual Wellness Visit (AWV)" Educational Tool — Revised

MLN Connects Provider eNews Special Edition - April 13, 2015

Attention Health Professionals: Information Regarding the 2015 Medicare Physician Fee Schedule

On April 1, 2015, the Medicare Physician Fee Schedule (MPFS) was updated using the Sustainable Growth Rate (SGR) methodology as required by current law. The SGR methodology required a 21% decrease in all MPFS payments beginning April 1, 2015. The Centers for Medicare & Medicaid Services (CMS) took steps to limit the impact on Medicare providers and beneficiaries by holding claims paid under the MPFS with dates of service on and after April 1, 2015. Additionally, Medicare is also holding all therapy claims that would no longer qualify for the therapy cap exceptions (those therapy claims with the 'KX' modifier), due to the expiration of the therapy cap exceptions process on April 1, 2015. In the absence of additional legislation to avert the negative update, CMS must update payment systems to comply with the law, and implement the negative update.

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Beginning on April 15th, 2015, CMS will release held MPFS claims, paying at the reduced rate, based on the negative update, on a first-in, first-out basis, while continuing to hold new claims as they are received. CMS will release one day's worth of held claims, processing and paying at the rate that reflects the negative update. At the same time, CMS will hold the receipts for that day, thus, continuing to hold 10 days' worth of claims in total. This is to provide continuing cash flow to providers, albeit at the rate that reflects the negative update. This "rolling hold" will help minimize the number of claims requiring reprocessing should Congress pass legislation changing the negative update.

Providers should remember that claims for services furnished on or before March 31, 2015 are not affected by the payment cut and will be processed and paid under normal time frames. We are working to limit any impact to Medicare providers and beneficiaries as much as possible. The MACs will automatically reprocess the claims paid at the reduced rate if Congressional action is taken to avert the negative update. No action is necessary from providers who have already submitted claims for the impacted dates of service.

MLN Connects Provider eNews – April 16, 2015

MLN Connects® Provider eNews for April 16, 2015

View this edition as a PDF

In This Edition:

MLN Connects® National Provider Calls

- Medicare Shared Savings Program ACO: Application Process — Last Chance to Register

CMS Events

- Volunteer for ICD-10 End-to-End Testing in July — Forms Due April 17

Announcements

- April is Sexually Transmitted Infections Month
- Is Your National Association an MLN Connects® Partner?
- LTCH Quality Reporting Program Data Submission Deadline: May 15
- IRF Quality Reporting Program Data Submission Deadline: May 15
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Proposed Rule Outlines EHR Requirements for Providers for 2015 through 2017

Medicare Learning Network® Educational Products

- "Medicare Quarterly Provider Compliance Newsletter [Volume 5, Issue 3]" Educational Tool — Released
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects Provider eNews – April 23, 2015

MLN Connects® Provider eNews for April 23, 2015

View this edition as a PDF

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In This Edition:

MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs — Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

Announcements

- Proposed FY 2016 Skilled Nursing Facility Payment and Policy Changes
- Proposed FY 2016 Inpatient and Long-Term Care Hospital Payment and Policy Changes
- DMEPOS Competitive Bidding Round 1 2017 Announced
- National Minority Health Month
- CMS Releases Hospital Compare Star Ratings
- New Hospice Reports Available in CASPER
- CMS to Release Transthoracic Echocardiography Comparative Billing Report in May
- CMS to Award Special Innovation Projects for Partnership-Driven Quality Improvement Projects
- CMS is Accepting Suggestions for Potential PQRS Measures

Claims, Pricers, and Codes

- Coordination of Benefits Issue Impacting Outpatient Hospital Claims
- Updated: Correcting the Display Issue for OPPS Claims Where Value Code "FD" Is Present

Medicare Learning Network® Educational Products

- "Independent Diagnostic Testing Facilities" Podcast — Released
- "Vaccine and Vaccine Administration Payments under Medicare Part D" Fact Sheet — Revised
- "Home Health Prospective Payment System" Fact Sheet — Revised
- "Medicare Fraud and Abuse: Prevention, Detection, and Reporting" Web-Based Training Course — Revised
- New Medicare Learning Network® Educational Web Guides Fast Fact

MLN Connects Provider eNews – April 30, 2015

MLN Connects® Provider eNews for April 30, 2015

View this edition as a PDF

In This Edition:

MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs — Register Now
- 2014 Mid-Year QRURs – Save the Date
- New MLN Connects® National Provider Call Video Slideshow, Audio Recordings and Transcripts

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Patient Survey Star Ratings

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Announcements

- Proposed FY 2016 Inpatient Rehabilitation Facility Payment and Policy Changes
- Proposed FY 2016 Inpatient Psychiatric Facility Payment and Policy Changes
- Focusing on Women's Health
- Open Payments Physician and Teaching Hospital Review and Dispute Period Ends May 20
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PV-PQRS GPRO Registration is Open
- Participation Continues to Rise in Medicare PQRS and eRx Incentive Program
- Antipsychotic Drug use in Nursing Homes: Trend Update
- Five Facts about ICD-10
- 2014 Mid-Year QRURs Available

Claims, Pricers, and Codes

- April 2015 Outpatient Prospective Payment System Pricer File Update
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality

Medicare Learning Network® Educational Products

- "Physicians and Non-Physician Practitioners Reported on Part A Critical Access Hospital (CAH) Claims" MLN Matters® Article — Released
- "Accreditation for Ventilators" MLN Matters® Article — Released
- "The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Repairs and Replacements" Fact Sheet — Revised
- New Medicare Learning Network® Provider Compliance Fast Fact
- Subscribe to the Medicare Learning Network® Educational Products and MLN Matters® Electronic Mailing Lists

MLN Connects Provider eNews – May 7, 2015

MLN Connects® Provider eNews for May 7, 2015

View this edition as a PDF

In This Edition:

MLN Connects® National Provider Calls

- Medicare Acute Care Quality and Reporting Programs for Hospitals — Last Chance to Register
- 2014 Mid-Year QRURs — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI — Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Webinar for Comparative Billing Report on Transthoracic Echocardiography

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Announcements

- Proposed Updates to Hospice Wage Index and Payment Rates
- May is National Osteoporosis Month
- Medicare Coverage for Viral Hepatitis
- New CDC Measles Information and Resources
- HHS Announces $101 Million in Affordable Care Act Funding to 164 New Community Health Centers
- Amendment to Disproportionate Share Hospital Ruling
- Inpatient Hospital Probe and Educate Extension
- Quality Reporting Programs: Updated 2014 eCQMs for 2016 Reporting
- CMS Announces the Physician Quality Reporting Programs Strategic Vision
- ICD-10 Resources for Medicare Providers
- Five More Facts about ICD-10
- Medscape Article for CME Credit: Improving Quality of Care through Care Coordination
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- FY 2016 Inpatient and LTCH PPS Proposed Rule: Comment Period Ends June 16
- CMS is Accepting Suggestions for Potential PQRS Measures

Medicare Learning Network® Educational Products

- "The Medicare Home Health Benefit" Web-Based Training Course — Released
- "Resources for Medicare Beneficiaries" Fact Sheet — Revised
- "Medicare Part B Immunization Billing" Educational Tool — Reminder
- Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects Provider eNews Special Edition – May 11, 2015

Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July - Forms Accepted May 11 through 22

Deadline extended

During the week of July 20 through 24, 2015, a final sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. CMS is accepting additional July volunteers from May 11 through 22, 2015. Don't miss your chance to participate in end-to-end testing with Medicare prior to the October 1, 2015, implementation date.

Approximately 850 volunteer submitters will be selected to participate in the July end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers. ***Note:*** Testers who are participating in the January and April end-to-end testing weeks are able to test again in July without re-applying.

To volunteer as a testing submitter:

- Volunteer forms are available on your MAC website
- Completed volunteer forms are due May 22
- CMS will review applications and select additional July testers
- The MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing by June 12

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If selected, testers must be able to:

- Submit future-dated claims.
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC for set-up purposes by the deadline on your acceptance notice; testers will be dropped if information is not provided by the deadline.

Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

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"

MLN Connects Provider eNews – May 14, 2015

MLN Connects® Provider eNews for May 14, 2015

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In This Edition:

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs — Register Now
- Medicare Shared Savings Program ACO: Application Review — Registration Now Open
- National Partnership to Improve Dementia Care and QAPI — Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 — Save the Date
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Register Now

MLN Connects® Videos

- New ICD-10 Videos: Impact on Inpatient Hospital Payment and Medicare Testing Plans

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

Announcements

- Depression is Not a Normal Part of Growing Older
- Therapy Caps Exceptions Process Extended through CY 2017
- Questions about Medicare?
- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- Groups: 6 Weeks Left to Register for 2015 PQRS GPRO

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Medicare Learning Network® Educational Products

- "Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model" MLN Matters® Article — Released
- "Items and Services That Are Not Covered Under the Medicare Program" Booklet — Revised
- Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects Provider eNews – May 21, 2015

MLN Connects® Provider eNews for May 21, 2015

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In This Edition:

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs - Register Now
- Medicare Shared Savings Program ACO: Application Review - Register Now
- National Partnership to Improve Dementia Care and QAPI - Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 - Registration Now Open
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X - Register Now

MLN Connects® Videos

- New Video on PQRS and the Value-Based Payment Modifier

CMS Events

- Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July - Forms Accepted May 11 through 22
- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5

Announcements

- 2014 Mid-Year QRURs Available
- EHR Proposed Rules Available for Comment: Stage 3 Comments Due by May 29
- Call for TEP Nominations: Closing Date June 1
- CMS to Release Comparative Billing Report on CT Scans of the Abdomen and Pelvis in June
- EHR Incentive Program: Deadline for Eligible Professional Hardship Exception is July 1
- PQRS: IACS Transitioning to EIDM on July 13
- CMS is Accepting Suggestions for Potential PQRS Measures

Medicare Learning Network® Educational Products

- "Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)" MLN Matters® Article - Released
- "Power Mobility Pearls for the Practicing Physician" Web-Based Training Course - Released
- "Clarification of the Use of Modifiers When Billing Wrong Surgery on a Patient" Podcast - Released
- "Co-Surgery Not Billed with Modifier 62" Podcast - Released
- "Chronic Care Management Services" Fact Sheet - Reminder
- New Medicare Learning Network® Educational Web Guides Fast Fact
- Medicare Learning Network Product® Available In Electronic Publication Format

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MLN Connects Provider eNews – May 28, 2015

MLN Connects® Provider eNews for May 28, 2015

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In This Edition:

MLN Connects® National Provider Calls

- 2014 Mid-Year QRURs — Last Chance to Register
- Medicare Shared Savings Program ACO: Application Review — Register Now
- National Partnership to Improve Dementia Care and QAPI — Register Now
- Hospice Quality and Hospice Item Set Manual V1.02 — Register Now
- ICD-10: Preparing for Implementation and New ICD-10-PCS Section X — Register Now
- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Registration Now Open
- ESRD QIP: Proposed Rule for Payment Year 2019 — Registration Now Open
- New MLN Connects® National Provider Call Audio Recording and Transcript

CMS Events

- Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5
- Special Open Door Forum: Home Health Quality Reporting Requirements
- Physician Compare Virtual Office Hour Session
- EHR Proposed Rules: Recordings and Presentations from Webinars

Announcements

- Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29
- 2015 PQRS GPRO: 4 Weeks Left to Register by June 30 Deadline
- HHS Awards $112 Million to Help 5,000 Primary Care Professionals Advance Heart Health
- Guidance on Beneficiary Disenrollments by Long Term Care Facilities

Claims, Pricers, and Codes

- ICD-10 FAQs: CMNs and Prescriptions
- Transition to ICD-10 for Home Health
- April 2015 IOCE Updated with ICD-10-CM Codes
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Mass Adjustment of FQHC PPS Claims

Medicare Learning Network® Educational Products

- "Medically Unlikely Edits Compliant" Podcast — Released
- "Electronic Prescribing (eRx) Incentive Program - A Compilation of 2013 Educational Resources" Booklet — Released
- "Medicare Appeals Process" Fact Sheet — Revised

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Correct Coding - BEMER Physical Vascular Therapy Devices

DME MAC Joint Publication

BEMER Physical Vascular Therapy Devices (BEMER International AG) provides broad spectrum, low intensity, pulsed, electromagnetic therapy which the manufacturer claims is effective for various conditions. This technology comes in differing configurations (Classic, Pro) and with a variety of accessories.

Questions for this device and related accessories should be directed to the Medicare Part B Carrier.

There is no DME HCPCS code assigned for these items that is valid for claim submission to the DME MACs. Consult with the Part B Contractor for coding and coverage guidance.

Claims submitted to the DME MACs for these items using Not Otherwise Classified (NOC) codes will be denied as wrong jurisdiction.

Claims submitted to the DME MACs for these items using existing "E" series HCPCS codes for electrical or electromagnetic devices such as TENS, neuromuscular stimulator, wound healing devices, joint stimulation devices etc. (not all-inclusive) will be denied as incorrect coding.

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

Quarterly HCPCS Drug/Biological Code Changes - July 2015 Update

MLN Matters® Number: MM9167
Related Change Request (CR) #: CR 9167
Related CR Release Date: May 8, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3254CP
Implementation Date: July 6, 2015

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 Medicare Administrative Contractors (DME/MACs) and Home Health & Hospice (HH&H) MACs for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 9167 and informs Medicare providers about the updating of specific drug and biological Healthcare Common Procedure Coding System **(**HCPCS) codes that occur quarterly. It alerts providers that the July file includes new HCPCS Codes.

CR9167 also updates Chapter 17, Section 20.1.2 (Average Sales Price (ASP) Payment Methodology) in the "Claims Processing Manual" to address the use of a compounded drug not otherwise classified (NOC) code on claims for compounded drugs. Make sure that your billing staffs are aware of these changes.

Summary of New HCPCS Codes in CR9167
CR9167 adds the following HCPCS codes with the effective dates noted.

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CODING

Table 1 - New HCPCS Codes in CR9167

Effective for Claims with Dates of Service on or after:	HCPCS Code	Long Description	Short Description	Type of Service (TOS)
March 6, 2015	Q5101	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	Inj filgrastim g-csf biosim	1, P
July 1, 2015	Q9976	Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron	Inj Ferric Pyrophosphate Cit	1,L
July 1, 2015	Q9978	Netupitant 300 mg and Palonosetron 0.5 mg, oral	Netupitant Palonosetron oral	1
July 1, 2015	Q9977	Compounded Drug, Not Otherwise Classified	Compounded Drug NOC	1, P

Note: The Medicare Physician Fee Schedule Status Indicator for all four codes above is E.

CR9167 also updates Section 20.1.2 Average Sales Price (ASP) Payment Methodology in Chapter 17 of the "Medicare Claims Processing Manual" to show that, beginning in July 2015, claims for compounded drugs should be submitted using a compounded drug, NOC HCPCS code.

Additional Information

The official instruction, CR 9167 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3254CP.pdf on the CMS website.

COMPETITIVE BID

Competitively Bid Wheelchair Accessories: KY Modifier Mass Adjustment

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-competitive bid wheelchair base units to beneficiaries residing in a Competitive Bid Area (CBA). The changes outlined in the CR were implemented by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) on January 5, 2015, and were effective for claims processed on or after January 5, 2015. These claims had previously been paid with the KY modifier at the Single Payment Amount instead of Fee Schedule.

Noridian has completed the mass adjustment for the following two scenarios; if you feel that you have additional claims that were not included in this mass adjustment, and are not pending by using the Interactive Voice Response (IVR) or our internet portal Endeavor, contact the Provider Contact Center for additional research and assistance. We will then advise you on the most appropriate next step.

Policy Scenarios

Scenario 1

In this scenario, MACs will pay the fee schedule amount (-9.5 percent) for the wheelchair accessory used with the non-bid wheelchair base rather than paying the single payment amount (SPA).

- Wheelchair accessory is competitively bid in Round 1 **and** Round 2;
- Billed for use with Complex Rehabilitative Group 2 (K0835-K0843) and Group 3 (K0848-K0864) Power Wheelchairs (i.e., wheelchair bases that were bid in Round 1, but not Round 2);
- Billed with modifier "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

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Scenario 4

In this scenario, MACs will pay the fee schedule amount for the wheelchair accessory.

- Wheelchair accessory is competitively bid in Round 2, but not Round 1;
- Billed for use with Complex Rehabilitative Group 2 (K0835-K0843) and Group 3 (K0848-K0864) Power Wheelchairs (i.e., wheelchair bases that were bid in Round 1, but not Round 2) **OR** 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 modifier "KY";
- Billed by a contract or non-contract supplier; and
- For a beneficiary that resides in a CBA.

Note: For wheelchair accessories, modifier "KY" is used in these instructions to identify Round 2 competitively bid wheelchair accessories that should be paid at fee schedule when billed for use with a base unit that was not bid in Round 2, even when provided to a beneficiary that resides in a CBA and without regard to the contract status of the supplier.

For more information, see MLN Matters 8864.

Quarterly Update for DMEPOS CBP - July 2015

MLN Matters® Number: MM9140
Related Change Request (CR) #: CR 9140
Related CR Release Date: May 8, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3256CP
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.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9140 to provide the DMEPOS Competitive Bidding Program (CBP) July 2015 quarterly update. CR9140 provides specific instructions to your DME MAC for implementing updates to the DMEPOS CBP Healthcare Common Procedure Coding System (HCPCS), ZIP code, and Single Payment Amount files. Note that quarterly updates are also available at http://dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/home on the Internet. At that site, click on the quarterly updates link in the left of the page.

Background

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

Under the program, a competition among suppliers who operate in a particular Competitive Bidding Area is conducted. Suppliers are required to submit a bid for selected products. Not all products or items are subject to competitive bidding. Bids are submitted electronically through a web-based application process

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and required documents are mailed. Bids are evaluated based on the supplier's eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the bid price amount. The amount is derived from the median of all winning bids for an item.

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

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

Additional Information

The official instruction, CR9140 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3256CP.pdf on the CMS website.

There are 14 separate products on pages four through six in the MLN Catalogue of Products at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf that describe the various aspects of the DMEPOS program. These fact sheets and booklets provide information for pharmacies, ways to pay for medical equipment, billing procedures for upgrades, repairs and replacements of equipment, and more.

Modifiers KK, KG, KU and KW used under the DMEPOS Competitive Bidding Program – Revised

MLN Matters® Number: MM9059 Revised
Related Change Request (CR) #: CR 9059
Related CR Release Date: March 27, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R1482OTN
Implementation Date: July 6, 2015

This article was revised on May 22, 2015, to reflect a revised Change Request (CR) 9059. That CR revised the remittance advice messages for adjusted claims. The transmittal number, CR release date and link to the CR also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for 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.

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

DME MACs will use the following messages when denying adjustment claim lines containing HCPCS inappropriately billed with modifiers KG, KK, KU, or KW:

- Group Code CO
- CARC 4 – "The procedure code 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 N211 – "Alert: You may not appeal this decision."

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COMPETITIVE BID

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/R1482OTN.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.

DOCUMENTATION

Billing Correct Date of Service for DMEPOS Items Obtained by Beneficiary

Noridian has been receiving an increase of Comprehensive Error Rate Testing (CERT) errors for suppliers billing the incorrect Date of Service (DOS) when a beneficiary is picking up a prescription or other DME item at a pharmacy. Based on Noridian's review of CERT errors from suppliers in Jurisdiction D, the supplier is billing the date the beneficiary called to request their prescription or item instead of the date the beneficiary has picked up the prescription or item. When a beneficiary picks up their prescription/item at a pharmacy, that date must be used as the DOS on the claim.

This scenario falls under Method 1 for Proof of Delivery (POD) requirements titled, "Direct Delivery to the Beneficiary by the Supplier". The documentation requirements within the Local Coverage Determinations (LCDs) state, "The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee."

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

EDUCATIONAL

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

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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

DMD on Demand - LCD and Policy Articles

DMD on Demand is an educational video featuring Noridian's DME Medical Director (DMD), Dr. Eileen Moynihan. This DMD on Demand explains the process for creating, updating and reviewing Local Coverage Determinations (LCDs) and Policy Articles for DMEPOS items.

Viewing Presentation

To view this video, go to the Message from the Medical Director page under Training and Events. All DMD on Demand videos will be listed here.

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

Join the Provider Outreach and Education Advisory Group Today!

Noridian is seeking representatives from a wide range of Medicare supplier specialties and associations to participate in the Jurisdiction D Provider Outreach and Education Advisory Group (POEAG). Today's healthcare environment involves many provisions and regulations, with Medicare being no exception as emphasis is placed on protecting the Medicare Trust Fund. The Affordable Care Act and ICD-10 are great examples of the many challenges currently facing the Durable Medical Equipment, Orthotics and Supplies (DMEPOS) community. DMEPOS stakeholders are needed to take an active role in providing input regarding areas where additional education is needed to address daily issues and challenges.

Our success as a contractor lies in the satisfaction of our customer. Through the POEAG, Noridian will be able to better communicate with and respond to the needs of those involved in administering care to Medicare beneficiaries. Noridian selects POEAG members to allow equitable provider representation based on the type of care provided and to recognize geographical diversity.

This is a unique opportunity for suppliers and stakeholders in the DMEPOS industry to take the stage and present ideas, concerns and feedback directly to Noridian. Active POEAG members will be included in discussions regarding current updates, upcoming events as well as new ideas.

Meetings are held quarterly via teleconference. For additional information on becoming a member visit the Education & Outreach section of the Noridian website and complete the membership application today!

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Blinatumomab (Blincyto) - Billing Instructions

DME MAC Joint Publication

Medicare encourages physicians, hospitals, other providers and suppliers to administer medication to patients in such a way that they use the drugs most efficiently, and in a clinically appropriate manner.

The dose or quantity of medication necessary to administer the prescribed amount is covered based upon the payment rules in the applicable medical policy. When the remainder of a single use vial or other single use package must be discarded after administering a dose of the drug to a Medicare patient, the program provides payment for the amount discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

Blinatumomab was recently approved for use by the Food and Drug Administration, and has been included in the DME MAC External Infusion Pump LCD as a covered drug for the treatment of Philadelphia negative relapsed/refractory acute lymphoblastic leukemia. Coverage is effective for claims with dates of service on or after December 03, 2014.

Blinatumomab is supplied in 35 mcg (lyophilized powder) single-use vials. The drug is reconstituted with sterile water in a USP <797> compliant facility, and placed in a bag coated with an IV Solution Stabilizer, which can be subsequently refrigerated (2°C to 8°C) for up to eight-days. A reconstituted bag contains 56 mcg, which is infused over 48 hours.

One unit of service (UOS) equals one (1) vial, and each UOS must be prepared using the combination of vials that result in the least amount of wastage for the dosage amount being administered. Five vials should be used to reconstitute three bags, each containing 56 mcg of blinatumomab, which can be refrigerated and used within six-days, leading to the least amount of wastage.

Using this method, usual utilization is 25 vials per month. Claims that exceed 25 UOS per month will be denied as not reasonable and necessary.

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

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

External Infusion Pumps (HCPCS E0781 and E0784) Notification of Documentation Compliance Review

Noridian Jurisdiction D, DME MAC, Medical Review will be initiating a documentation compliance review of the following HCPCS code(s):

E0781: AMBULATORY INFUSION PUMP, SINGLE OR MULTIPLE CHANNELS, ELECTRIC OR BATTERY OPERATED, WITH ADMINISTRATIVE EQUIPMENT, WORN BY PATIENT

E0784: EXTERNAL AMBULATORY INFUSION PUMP, INSULIN

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. This review is being initiated based on the complex medical review results.

View complete details on the Medical Review page.

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Claims Submitted by Multiple DMEPOS Suppliers – Pub. 100-04, Chapter 1

MLN Matters® Number: MM9079
Related Change Request (CR) #: CR 9079
Related CR Release Date: May 15, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3262CP
Implementation Date: July 6, 2015

Provider Types Affected

This MLN Matters® Article is intended for durable medical equipment prosthetic, orthotics, and suppliers (DMEPOS) submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for supplies and services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 9079, which instructs DME MACs that effective July 1, 2015, when a second supplier submits a diabetic test strip claim for a span date already approved for the same beneficiary from a different supplier, the DME MAC will deny the second supplier's claim as a duplicate claim, rather than a suspect duplicate claim. Make sure that your billing staffs are aware of this change.

Background

CR 9079 informs DME MACs that manual Subsection, 120.2 D, "Claims Submitted by Multiple DMEPOS Suppliers Multiple Suppliers," has been added to Chapter 1 of the "Medicare Claims Processing Manual."

CR9079 Manual Update

Effective July 1, 2015, when a second supplier submits a diabetic test strip claim for a span date already approved for the same beneficiary for a different supplier, the DME MAC will deny the second supplier's claim as a duplicate claim, when the following conditions are met:

- Same Beneficiary Health Insurance Claim Number (HICN);
- Overlapping span Date of Service (DOS) (From DOS and Through DOS);
- Same Healthcare Common Procedure Coding System (HCPCS) Code;
- Same Type of Service on the incoming claim matches a previously approved claim in history; and
- The item is a diabetic testing supply.

Additional Information

The official instruction, CR 9079, issued to your MAC regarding this change, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3262CP.pdf on the CMS website.

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Five Facts about ICD-10

To help dispel some of the myths surrounding ICD-10, the Centers for Medicare & Medicaid Services (CMS) recently talked with providers to identify common misperceptions about the transition to ICD-10. These five facts address some of the common questions and concerns CMS has heard about ICD-10:

1. **The ICD-10 transition date is October 1, 2015.**
   The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.
2. **You don't have to use 68,000 codes.**
   Your practice does not use all 13,000 diagnosis codes available in ICD-9. Nor will it be required to use the 68,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.
3. **You will use a similar process to look up ICD-10 codes that you use with ICD-9.**
   Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help you with code selection.
4. **Outpatient and office procedure codes aren't changing.**
   The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT.
5. **All Medicare fee-for-service providers have the opportunity to conduct testing with CMS before the ICD-10 transition.**
   Your practice or clearinghouse can conduct acknowledgement testing at any time with your Medicare Administrative Contractor (MAC). Testing will ensure you can submit claims with ICD-10 codes. During a special "acknowledgement testing" week to be held in June 2015, you will have access to real-time help desk support. Contact your MAC for details about testing plans and opportunities.

Stay tuned for five more facts about ICD-10: coming to you soon in another CMS ICD-10 Email Update message.

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 April 23, 2015

ICD-10 Acknowledgement Testing with Providers – Revised

MLN Matters® Number: MM8858 Revised
Related Change Request (CR) #: CR 8858
Related CR Release Date: February 24, 2015
Effective Date: 30 Days from Issuance (See test dates)
Related CR Transmittal #: R14720TN
Implementation Date: November 17 through 21, 2014, for the November Testing Week; March 2 through 6, 2015 for the March Testing Week; June 1 through 5, 2015, for the June Testing Week

This article was revised on February 27, 2015, to reflect the revised CR8858, issued on February 24. In the article, the CR release date, transmittal number, and the Web address for accessing CR8858 are revised. All other information remains the same.

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Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8858 instructs MACs to promote three specific acknowledgement testing weeks with providers, and provide data and statistics to the Centers for Medicare & Medicaid Services (CMS) to demonstrate readiness for the International Classification for Disease 10th Edition Clinical Modification (ICD-10) transition. Make sure that your billing staffs are aware of these ICD-10 testing opportunities.

Background

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing ICD-10. All covered entities must be fully compliant on October 1, 2015.

CR8858 instructs all MACs and the DME MAC Common Electronic Data Interchange (CEDI) contractor to promote ICD-10 Acknowledgement Testing with trading partners during three separate testing weeks, and to collect data about the testing. These testing weeks will be:

- November 17 – 21, 2014
- March 2 – 6, 2015
- June 1 – 5, 2015

The concept of trading partner testing was originally designed to validate the trading partners' ability to meet technical compliance and performance processing standards during the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010 implementation. While submitters may acknowledgement test ICD-10 claims at any time through implementation, the ICD-10 testing weeks have been created to generate awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

These testing weeks will allow trading partner's access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on the CMS website, the CEDI website and each MAC's website.

Key Points of the Testing Process for CR8858

- Test claims with ICD-10 codes must be submitted with current dates of service since testing does not support future dates of service.
- Claims will be subject to existing NPI validation edits.
- MACs and CEDI will be staffed to handle increased call volume during this week.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected by Medicare.
- Test claims will be subject to all existing EDI front-end edits, including Submitter authentication and NPI validation.
- Testing will not confirm claim payment or produce a remittance advice.
- 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 this week.
- Your MAC will announce and promote these testing weeks via their listserv messages and their website.

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Additional Information

The official instruction, CR8858 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1472OTN.pdf on the CMS website.

The EDI help desk numbers for institutional claim submitters are available at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartA.pdf on the CMS website and the numbers for professional claims submitters are available at http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/downloads/EDIHelplinePartB.pdf on the CMS website.

Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality

On October 1, 2015, ICD-10-CM will replace the ICD-9-CM code set currently used by providers for reporting diagnosis codes. Implementation of ICD-10-CM will not change the reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, providers will continue to follow CPT and CMS guidance in reporting CPT/HCPCS modifiers for laterality.

Transition to ICD-10

Spread the Word about the Transition to ICD-10

Join the CMS ICD-10 Social Media Rally

1. Visit the ICD-10 Thunderclap Page
2. Log in using your Facebook, Twitter, or Tumblr account
3. Join the rally to spread the word about ICD-10

What Happens Next?

When the campaign reaches its goal of 100 participants, this message will be automatically released from participants' selected accounts on Thursday, April 16, 2015 at 9 am ET / 8 am CT: "I'm on the #RoadtoICD10. Get ready for Oct 1, 2015. #ICD10 http://cms.gov/ICD10"

The result will be a "thunderclap" of simultaneous Twitter, Facebook, and Tumblr posts about ICD-10 that will reverberate across social media.

Please note the message will be released from your designated account on Thursday, April 16, 2015, at 9 am ET / 8 am CT only if the supporter goal is met. Thunderclap will post to your account only **one time.**

Why Join the CMS ICD-10 Social Media Rally?

The transition to ICD-10 marks an important step forward for our nation's health care system. By spreading the word, you will show your commitment to preparing, and you will encourage others to get ready by **October 1, 2015.**

Stay Informed

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: CMSLIST Email Update dated April 8, 2015

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Immunosuppressive Drugs (HCPCS J7507, J7517, J7518 and 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(s) J7507, J7517, J7518 and J7520. The quarterly edit effectiveness results from December 2014 through March 2015 are as follows:

The J7507 review involved 3,737 claims, of which 2,544 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **64%**.

The J7517 review involved 2,176 claims, of which 1,499 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **66%**.

The J7518 review involved 1,647 claims, of which 1,055 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **59%**.

The J7520 review involved 458 claims, of which 304 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **64%**.

View top denial reasons and educational resources on the Medical Review page.

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

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from September 2014 through December 2014 are as follows:

- The J7507 review currently has an overall potential improper payment rate of 72%.
- The J7517 review currently has an overall potential improper payment rate of 71%.
- The J7518 review currently has an overall potential improper payment rate of 68%.
- The J7520 review currently has an overall potential improper payment rate of 72%.

For complete details, see Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Service Specific Prepayment Review.

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

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from November 2014 through January 2015 are as follows:

The J7507 review currently has an overall potential improper payment rate of 64%, J7517 has an overall potential improper payment rate of 66%, J7518 has an overall potential improper payment rate of 59% and the J7520 review currently has an overall potential improper payment rate of 64%.

For complete details, see Immunosuppressive Drugs (HCPCS J7507, J7517, J7518, J7520) Quarterly Results of Service Specific Prepayment Review.

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LCD and Policy Article Revisions Summary for March 5, 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.

Cervical Traction Devices

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 E0856
DOCUMENTATION REQUIREMENTS:
Added: Items provided on a periodic basis requirements to DWO
Revised: Standard language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
Revised: HCPCS E0856 Narrative in ACA table
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: HCPCS E0856 Narrative in ACA table
Removed: "When required by state law" from ACA new prescription requirements

Hospital Beds and Accessories

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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: 10/31/2014
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

Intravenous ImmuneGlobulin

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Refill 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

Policy Article

Revision Effective Date: 01/01/2011 (March 2015 Publication)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: ICD-9 codes from this section
Added: Reference to ICD-9 codes section

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Mechanical In-exsufflation Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Revised: Removed ICD-9 reference from diagnosis code statement

Policy Article

Revision Effective Date: 10/31/2014
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

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.

LCD and Policy Article Revisions Summary for March 12, 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.

Negative Pressure Wound Therapy Pumps

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Removed: ICD-9 CM reference

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: HCPCS Code A9272 (code effective 01/01/2012) to statement regarding denial of disposable wound suction pumps and related supplies
CODING GUIDELINES:
Added: Instructions for billing disposable wound suction system
Revised: Instructions for billing supplies used with disposable wound suction systems

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Language
Added: Language from RAD LCD allowing Sleep study Types II, III, IV testing in facility setting
DOCUMENTATION REQUIREMENTS:
Revised: Standard Language

RETIRED

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Standard language reference to benefit category citation in Social Security Act.
Added: Statutory denial for liners
Revised: Face-to-Face Standard Language
CODING GUIDELINES:
Added: Correct coding of liners
Added: Correct coding of monitoring technology

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.

LCD and Policy Article Revisions Summary for March 19, 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.

Heating Pads and Heat Lamps

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language regarding Medicare coverage
DOCUMENTATION REQUIREMENTS:
Added: Instructions for Refill Documentation
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Revised: Moved Continued Need above Continued Use documentation
Added: Equipment Retained from a Prior Payer
Added: Instructions for Repair Replacement to beneficiary-owned DMEPOS

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Removed: Refill Requirements
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Removed: Request for refill documentation requirements
Added: Instructions for Equipment Retained from a Prior Payer
Added: Instructions for Repair Replacement

Policy Article

Revision Effective Date: 10/31/2014
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

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.

RETIRED

LCD and Policy Article Revisions Summary for March 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.

Canes and Crutches

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Revised: Repair to beneficiary-owned DMEPOS

Cold Therapy

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Standard Documentation Language

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2015 (March 2015 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Maximum utilization for Blinatumomab; inadvertently omitted
DOCUMENTATION REQUIREMENTS:
Revised: Instructions for Revised DIF
Added: Instructions for Recertification DIF

Policy Article

Revision Effective Date: 01/01/2015 (March 2015 Publication)
CODING GUIDELINES:
Revised: Units of service for and blinatumomab
Added: Instructions for least wastage of blinatumomab; inadvertently omitted from previous publication

Infrared Heating Pad System

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: Added Appendices verbiage

Manual Wheelchair Bases

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Instructions for Refill Documentation
Added: Equipment Retained from a Prior Payer
Revised: Repair to beneficiary-owned DMEPOS

RETIRED

Policy Article

Revision Effective Date: 10/31/2014
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

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.

LCD and Policy Article Revisions Summary for April 2, 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.

Commodes

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Deleted: Reference to refill of supplies from Continued Use
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
Revised: Repair to beneficiary-owned DMEPOS

Immunosuppressive Drugs

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: ICD-9 CM reference

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: ICD-9 diagnosis references
CODING GUIDELINES:
Revised: J7599 billing guidelines

Intrapulmonary Percussive Ventilation System

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: PIM citation reference under Appendices

RETIRED

Oral Appliances for Obstructive Sleep Apnea

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: Continued Medical Need/Continued Use sections
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 SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Diagnosis code reference

Policy Article

Revision Effective Date: 01/01/2015
CODING GUIDELINES:
Revised: Coding Guidelines based on DME MAC article: "Correct Coding for Oral Appliances for the Treatment of Obstructive Sleep Apnea (E0486)" – Effective July, 01, 2012

Osteogenesis Stimulators

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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: 10/31/2014
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

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.

LCD and Policy Article Revisions Summary for April 9, 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.

Orthopedic Footwear

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Added: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Removed: ICD-9 references
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Added: Instructions for Equipment Retained from a Prior Payer

RETIRED

Patient Lifts

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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: 10/31/2014
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
Vacuum Erection Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: WOPD standard language

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.

LCD and Policy Article Revisions Summary for April 23, 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.

Pressure Reducing Support Surfaces – Group 2

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Removed: ICD-9 references
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 and Replacement section

RETIRED

Pressure Reducing Support Surfaces – Group 3

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Added: Standard Documentation Language for detailed written order
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
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
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
Seat Lifts Mechanisms

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements
Revised: Face-to-Face Requirements for treating practitioner

Therapeutic Shoes for Persons with Diabetes

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Removed: ICD-9 reference

Policy Article

Revision Effective Date: 11/01/2014 (April 2015 Publication)
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Reference to ICD-9 Codes in the narrative
CODING GUIDELINES:
Revised: PDAC verbiage

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.

RETIRED

LCD and Policy Article Revisions Summary for April 30, 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.

Ankle-Foot/Knee-Ankle-Foot Orthoses

LCD

Revision Effective Date: 05/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: Continued Need & Continue Use
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
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Updated: Documentation responsibilities for prefabricated vs. custom fabricated devices to reflect revision of April 2015 bulletin article
Revised: Repair to beneficiary-owned DMEPOS
Revised: Instructions for HCPCS L2999

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information for hospital and SNF reimbursement
CODING GUIDELINES:
Added: Reference to classification algorithm summary

Knee Orthoses

LCD

Revision Effective Date: 05/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Added: Continued Need and Continued Use
Revised: Standard language to add who can enter date of delivery date on the POD
Added: Instructions for Equipment Retained from a Prior Payer
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Updated: Documentation responsibilities for prefabricated vs. custom fabricated devices to reflect revision of April 2015 bulletin article
Revised: Repair to beneficiary-owned DMEPOS
Revised: Instructions for HCPCS L2999

Policy Article

Revision Effective Date: 01/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Information for hospital and SNF reimbursement

Spinal Orthoses: TLSO and LSO

LCD

Revision Effective Date: 05/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Deleted: Reference to refill of supplies from Continued Use
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

RETIRED

Added: Instructions for Equipment Retained from a Prior Payer
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: L0455 requires the CG modifier
Revised: Documentation responsibilities for prefabricated vs. custom fabricated devices to reflect revision of April 2015 bulletin article
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
CODING GUIDELINES:
Added: L0455 added to paragraph regarding items made of primarily nonelastic material

Suction Pumps

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Revised: Diagnosis code references
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
Revised: Diagnosis code references

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.

LCD and Policy Article Revisions Summary for May 7, 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.

Automatic External Defibrillators

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
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

Enteral Nutrition

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

RETIRED

Added: Instructions for Equipment Retained from a Prior Payer
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Instructions for Recertification DIF

Policy Article

Revision Effective Date: 10/31/2014
CODING GUIDELINES:
Updated: Standard language documentation for PDAC coding verification

External Breast Prostheses

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Moved: Continued Need above Continued Use documentation
Added: Instructions to the Refill Documentation section
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Equipment Retained from a Prior Payer

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Revised: 3-drug combination coverage - Akynzeo® (netupitant with palonosetron) NK-1/5HT3 antagonist available - effective on and after 10/10/2014
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Akynzeo® to the 3-drug combination billing and modifier instructions, effective on and after 10/10/2014

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: HCPCS Codes J8650, Q0161 – Q0180 to oral antiemetic drug coverage criteria
Revised: 3-drug combination regimen - Akynzeo® (netupitant with palonosetron) NK-1/5HT3 antagonist available - effective on and after 10/10/2014
CODING GUIDELINES:
Added: Akynzeo® (netupitant with palonosetron) NK-1/5HT3 antagonist available - effective on and after 10/10/2014

Parenteral Nutrition

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Instructions for Recertification DIF

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.

RETIRED

LCD and Policy Article Revisions Summary for May 14, 2015

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Glucose Monitor, Pneumatic Compression Devices, Respiratory Assist Devices, Wheelchair Options/Accessories, and Wheelchair Seating. Please review each entire LCD and each related PA for complete information.

Glucose Monitor

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
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

Pneumatic Compression Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Replaced: WOPD with ACA 6407 WOPD instructions
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
Revised: Standard Language Documentation verbiage for CMN
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014
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

Respiratory Assist Devices

LCD

Revision Effective Date: 12/01/2014 (May 2015 Publication)
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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: 12/01/2014 (May 2015 Publication)
NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES:
Added: Non-coverage statement for liners used in conjunction with a PAP mask
Removed: "When required by state law" from ACA new prescription requirements

RETIRED

CODING GUIDELINES:
Added: Coding guidelines for liners used with PAP mask based on DME MAC article posted on February 13, 2014
Added: Coding guidelines for Monitoring Technology based on DME MAC article posted on November 15, 2013

Wheelchair Options/Accessories

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Added: HCPCS Codes E2358 and E2359 to the Batteries/Chargers section
DOCUMENTATION REQUIREMENTS:
Deleted: Reference to refill of supplies from Continued Use
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014
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:
Revised: Removed HCPCS K0017 and K0018 from the initial package verbiage for armrest separate billing due to being parts of the whole assembly E0973 and only separately billed for replacement parts
Added: E0973 was added to the initial package verbiage for armrest separate billing due to being the whole assembly
Removed: The word "adjustable" was removed from the initial package verbiage for armrest separate billing due to fixed armrests K0020 being included

Wheelchair Seating LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Deleted: Reference to refill of supplies from Continued Use
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014
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

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.

LCD and Policy Article Revisions Summary for May 21, 2015

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Speech Generating Devices, Transcutaneous Electrical Joint Stimulation Devices (TEJSD), Transcutaneous Electrical Nerve Stimulators (TENS) and Vacuum Erection Devices (VED). Please review each entire LCD and each related PA for complete information.

RETIRED

Speech Generating Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
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

Transcutaneous Electrical Joint Stimulation Devices (TEJSD)

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Revised: Standard Documentation Language for WOPD to make consistent with ACA requirements
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language for WOPD to make consistent with ACA 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

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements

Transcutaneous Electrical Nerve Stimulators (TENS)

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language for WOPD to make consistent with ACA 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: 10/31/2014
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

Vacuum Erection Devices (VED)

LCD

Revision Effective Date: 07/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Changed coverage indications for L7900 and L7902 to non-covered based on Achieving a Better Life Experience (ABLE) Act of 2014

RETIRED

Policy Article
Revision Effective Date: 07/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Changed coverage to non-covered based on ABLE Act of 2014

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.

LCD and Policy Article Revisions Summary for May 21, 2015

Outlined below are the principal changes to DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Speech Generating Devices, Transcutaneous Electrical Joint Stimulation Devices (TEJSD), Transcutaneous Electrical Nerve Stimulators (TENS) and Vacuum Erection Devices (VED). Please review each entire LCD and each related PA for complete information.

Speech Generating Devices

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
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
Revised: Repair to beneficiary-owned DMEPOS

Policy Article

Revision Effective Date: 10/31/2014
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

Transcutaneous Electrical Joint Stimulation Devices (TEJSD)

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
Revised: Standard Documentation Language for WOPD to make consistent with ACA requirements
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language for WOPD to make consistent with ACA 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

Policy Article

Revision Effective Date: 10/31/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: "When required by state law" from ACA new prescription requirements

Transcutaneous Electrical Nerve Stimulators (TENS)

LCD

Revision Effective Date: 10/31/2014
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility
DOCUMENTATION REQUIREMENTS:
Revised: Standard Documentation Language for WOPD to make consistent with ACA requirements
Revised: Standard Documentation Language to add who can enter date of delivery date on the POD

RETIRED

Added: Instructions for Equipment Retained from a Prior Payer
Added: Repair/Replacement section

Policy Article

Revision Effective Date: 10/31/2014
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

Vacuum Erection Devices (VED)

LCD

Revision Effective Date: 07/01/2015
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Changed coverage indications for L7900 and L7902 to non-covered based on Achieving a Better Life Experience (ABLE) Act of 2014

Policy Article

Revision Effective Date: 07/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Changed coverage to non-covered based on ABLE Act of 2014

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.

Correct Coding - Weightless Walker

DME MAC Joint Publication

The Weightless Walker (Weightless Walker, Inc.) is an enclosed, wheeled walker with a seat. The correct HCPCS code for billing this item to Medicare is:

E0144 - WALKER, ENCLOSED, FOUR SIDED FRAMED, RIGID OR FOLDING, WHEELED WITH POSTERIOR SEAT

Refer to the Walkers LCD and related Policy Article for information about coverage and documentation.

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.

Correct Coding - WHILL Model A Powered Personal Mobility Device

DME MAC Joint Publication

The WHILL Model A (Whill, Inc., San Carlos, CA) is a powered personal mobility device designed "…to improve the mobility for all, not just those with a disability."[1]. As noted by the manufacturer, this product has not been submitted to the FDA and is not considered to be a medical device. Consequently, this item is non-covered (no Medicare benefit).

For Medicare billing purposes, claims for this device must be submitted using HCPCS code:

A9270 – NONCOVERED ITEM OR SERVICE

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

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

RETIRED

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

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

[1] www.whill.us/faq, access April 10, 2015

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 December 2014 through February 2015 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.
- 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.
- 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.

View complete information on the PMD Prior Authorization page under CERT & Reviews.

Power Mobility Devices and All Related Accessories (HCPCS K0823) 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 K0823 and all related accessories. The final edit effectiveness results from October 2014 through February 2015 are as follows:

The **K0823** review involved 273 claims, of which 145 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **54%**.

View top denial reasons and educational resources on the Medical Review page.

RETIRED

ORAL ANTI-EMETIC DRUGS

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

This is a revision to previous version published January 15, 2015.

Joint DME MAC Publication

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.

ORAL ANTI-EMETIC DRUGS

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

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

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

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

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

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

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

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

If Akynzeo® (Q0181 or Q9978) 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 and related Policy Article for further information on coverage, documentation and coding.

ORTHOTICS AND PROSTHETICS

Correct Coding – LIM innovations Infinite Socket™

DME MAC Joint Publication

LIM innovations Infinite Socket™ TF C1 is a prefabricated modular above-knee design that has recently become available. This product uses four struts that extend from the base to an adjustable brim to form the structure of the item.

The existing HCPCS L-codes used for above-knee lower limb prosthesis sockets describe items which enclose the residual limb to provide the stability, proprioception, and suspension necessary for the effective use of the artificial limb. This product is sufficiently different in design and construction that existing L-codes for sockets and socket additions are inappropriate for use with this product. Claims for this item using existing L-codes will be denied as incorrect coding.

As a defined-benefit program, the first requirement for any item to be potentially eligible for Medicare reimbursement is that the item must qualify for inclusion into an existing benefit category. There is no evidence in the clinical literature demonstrating that this design is able to function effectively as a socket for a lower limb prosthesis. Therefore, the item does not qualify for inclusion in the Artificial Limbs benefit

RETIRED

category. The correct code to use for Medicare claims for this item is:

A9270 – NONCOVERED ITEM OR SERVICE

This coding determination is all-inclusive. Separate billing for options, accessories, additions, etc. used with this product will be denied as unbundling.

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

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

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 November 2014 through February 2015 are as follows:

The L5980 review involved 56 claims, of which 42 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 67%.

View top denial reasons and educational resources on the Medical Review page.

VES Prosthetic Devices - Discontinued Coverage in Accordance with the Achieving a Better Life Experience Act of 2014

MLN Matters® Number: SE1511

Provider Types Affected

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

Provider Action Needed

Medicare currently pays for coverage of Vacuum Erection Systems (VES) prosthetic devices and related accessories, when reasonable and necessary. This article notifies suppliers of changes to the July DMEPOS Fee Schedule related to VES devices and instructs the DME MACs to implement changes to prohibit payment on claims for VES prosthetic devices (Healthcare Common Procedure Codes (HCPCS) L7900 and L7902) for dates of service on or after July 1, 2015.

Section 203 of the Achieving a Better Life Experience (ABLE) Act of 2014 implements changes to treat VES prosthetic devices and related accessories as statutorily noncovered in the same manner that erectile dysfunction drugs are treated in Part D. Effective for claims with dates of service on or after July 1, 2015, DME MACs will deny claims submitted with HCPCS codes L7900 and L7902.

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

Background

As of July 1, 2015, HCPCS codes L7900 and L7902 codes are statutorily excluded from Medicare coverage and, therefore, are not payable when billed to Medicare. The Centers for Medicare & Medicaid Services (CMS) has issued instructions to the DME MACs to begin changes that are necessary to deny coverage for the following HCPCS codes for VES and related accessories effective for dates of service on or after July 1, 2015:

- L7900 - Male Vacuum Erection System
- L7902 - Tension Ring, for vacuum erection device, any type, replacement only, each

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Pursuant to the above, DME MACs will deny such claims using Remittance Advice Remarks Code N425 (Statutorily excluded service(s).) and a Group Code of PR (Patient responsibility).

Additional Information

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

Correct Coding – Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Revised

Joint DME MAC Publication

This is a revision to a previously article published March 27, 2014.

As part of the 2014 and 2015 HCPCS update, codes were created describing certain off-the-shelf (OTS) orthotics. Some of these codes parallel codes for custom fitted versions of the same items. Refer to the table at the end of this article for a listing of codes.

When providing these items suppliers must:

- Provide the product that is specified by the ordering physician
- Be sure that the ordering physician's medical record justifies the need for the type of product (i.e., Prefabricated versus Custom Fabricated)
- Only bill for the HCPCS code that accurately reflects both the type of orthosis and the appropriate level of fitting.
- Have detailed documentation in the supplier's record that justifies the code selected

The following definitions will be used for correct coding of these items.

Off-the-shelf (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.

Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient may be considered as OTS if the final fitting upon delivery to the patient requires minimal self-adjustment as described in this section.

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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.

Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient may be considered as custom fitted if the final fitting upon delivery to the patient requires substantial modification requiring expertise as described in this section.

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.

Kits are:

- A collection of components, materials and parts that require further assembly before delivery of the final product.
- The elements of a kit may be packaged and complete from a single source or may be an assemblage of separate components from multiple sources by the supplier.

A summary classification algorithm and table is included at the end of this document to assist with determinations about the type of product and correct code selection.

Refer to the Contractor Supplier Manual, applicable Local Coverage Determination and related Policy Article for additional information about other 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.

Classification Algorithm – Overview of Criteria

Determining Proper Coding of Prefabricated Orthotics

The following question and answer relates to whether a prefabricated orthotic is properly billed using a code for a custom fitted orthotic versus one furnished off-the-shelf and does not address medical necessity for the item. The descriptors for the HCPCS codes for custom fitted orthotics include the following nomenclature:

- Off-the-shelf (OTS) - Prefabricated item that requires minimal self-adjustment such as being trimmed, bent, molded, assembled, or otherwise adjusted to fit the beneficiary. Minimal self-adjustment does not require the expertise of a certified orthotist or an individual with equivalent expertise.
- Custom fitted - Prefabricated item that requires substantial modification e.g., has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by certified orthotist or an individual with equivalent expertise.

Question: Is the prefabricated orthotic furnished with custom fitting that is and can only be provided by an individual with expertise or furnished off-the-shelf (OTS)?

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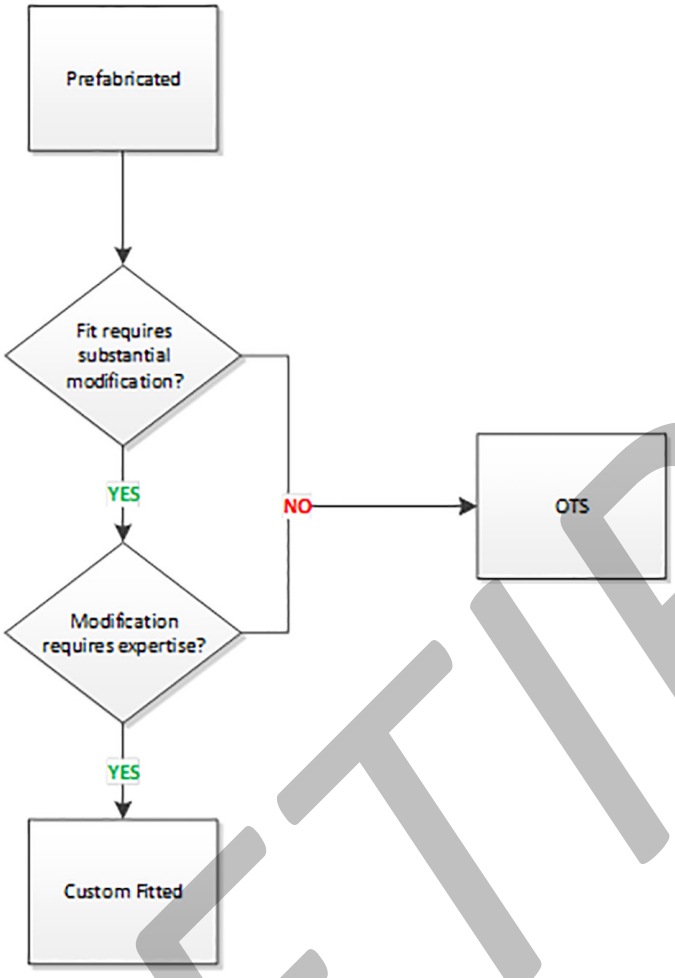
Answer: Classification depends on (1) what must be done at final fitting and (2) who must do it. Expertise of a qualified practitioner and substantial modification at the time of delivery qualify the items for classification as custom fitted. Fail either one of these criteria and the item is classified as off-the-shelf.

How to Decide What Code Type for Prefabricated Orthotic



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2015 HCPCS New Code Table

Note 1: Some Custom Fitted codes do not have corresponding OTS codes. If items described by these codes are furnished off-the-shelf without custom fitting or with fitting performed by someone without expertise in fitting, the corresponding code for the broader category of orthotics not otherwise specified in the HCPCS (e.g., L1499 for Spinal Orthosis, Not Otherwise Specified) should be used. The supplier should indicate in the narrative field for the claim that the orthotic was furnished off-the-shelf.

Note 2: Not all new codes listed have a corresponding medical policy. There are policies for Ankle/Foot and Knee/Ankle/Foot Orthosis, Knee Orthosis and Spinal Orthosis. There are no medical policies for Hip, Wrist, Hand, Finger or Shoulder Orthosis

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
L0454	TLSO Flexible, Provides Trunk Support, Extends from Sacrococcygeal Junction to Above T-9 Vertebra, Restricts Gross Trunk Motion in the Sagittal Plane, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Disks with Rigid Stays or Panel(S), Includes Shoulder Straps and Closures, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0455	TLSO Flexible, Provides Trunk Support, Extends from Sacrococcygeal Junction to Above T-9 Vertebra, Restricts Gross Trunk Motion in the Sagittal Plane, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Disks with Rigid Stays or Panel(S), Includes Shoulder Straps and Closures, Prefabricated, Off-The-Shelf
L0456	TLSO, Flexible, Provides Trunk Support, Thoracic Region, Rigid Posterior Panel and Soft Anterior Apron, Extends from the Sacrococcygeal Junction and Terminates Just Inferior to the Scapular Spine, Restricts Gross Trunk Motion in the Sagittal Plane, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Disks, Includes Straps and Closures, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0457	TLSO, Flexible, Provides Trunk Support, Thoracic Region, Rigid Posterior Panel and Soft Anterior Apron, Extends from the Sacrococcygeal Junction and Terminates Just Inferior to the Scapular Spine, Restricts Gross Trunk Motion in the Sagittal Plane, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Disks, Includes Straps and Closures, Prefabricated, Off-The-Shelf
L0460	TLSO, Triplanar Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends from the Sacrococcygeal Junction and Terminates Just Inferior to the Scapular Spine, Anterior Extends from the Symphysis Pubis to the Sternal Notch, Soft Liner, Restricts Gross Trunk Motion in the Sagittal, Coronal, and Transverse Planes, Lateral Strength is Provided by Overlapping Plastic and Stabilizing Closures, Includes Straps and Closures, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise		No Corresponding Code
L0466	TLSO, Sagittal Control, Rigid Posterior Frame and Flexible Soft Anterior Apron with Straps, Closures and Padding, Restricts Gross Trunk Motion in Sagittal Plane, Produces Intracavitary Pressure to Reduce Load on Intervertebral Disks, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0467	TLSO, Sagittal Control, Rigid Posterior Frame And Flexible Soft Anterior Apron with Straps, Closures and Padding, Restricts Gross Trunk Motion in Sagittal Plane, Produces Intracavitary Pressure to Reduce Load on Intervertebral Disks, Prefabricated, Off-The-Shelf

RETIRED

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
L0468	TLSO, Sagittal-Coronal Control, Rigid Posterior Frame and Flexible Soft Anterior Apron with Straps, Closures and Padding, Extends from Sacrococcygeal Junction Over Scapulae, Lateral Strength Provided by Pelvic, Thoracic, and Lateral Frame Pieces, Restricts Gross Trunk Motion in Sagittal, and Coronal Planes, Produces Intracavitary Pressure to Reduce Load on Intervertebral Disks, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0469	TLSO, Sagittal-Coronal Control, Rigid Posterior Frame and Flexible Soft Anterior Apron with Straps, Closures and Padding, Extends from Sacrococcygeal Junction Over Scapulae, Lateral Strength Provided by Pelvic, Thoracic, and Lateral Frame Pieces, Restricts Gross Trunk Motion in Sagittal, and Coronal Planes, Produces Intracavitary Pressure to Reduce Load on Intervertebral Disks, Prefabricated, Off-The-Shelf
L0626	Lumbar Orthosis, Sagittal Control, with Rigid Posterior Panel(S), Posterior Extends from L-1 to Below L-5 Vertebra, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures, May Include Padding, Stays, Shoulder Straps, Pendulous Abdomen Design, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0641	Lumbar Orthosis, Sagittal Control, with Rigid Posterior Panel(S), Posterior Extends from L-1 to Below L-5 Vertebra, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures, May Include Padding, Stays, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
L0627	Lumbar Orthosis, Sagittal Control, with Rigid Anterior and Posterior Panels, Posterior Extends from L-1 to Below L-5 Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures,Vertebra, Produces Intracavitary May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0642	Lumbar Orthosis, Sagittal Control, with Rigid Anterior and Posterior Panels, Posterior Extends from L-1 to Below L-5 Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures,Vertebra, Produces Intracavitary May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
L0630	Lumbar-Sacral Orthosis, Sagittal Control, with Rigid Posterior Panel(S), Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures, May Include Padding, Stays, Shoulder Straps, Pendulous Abdomen Design, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0643	Lumbar-Sacral Orthosis, Sagittal Control, with Rigid Posterior Panel(S), Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures, May Include Padding, Stays, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf

RETIRED

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
L0631	Lumbar-Sacral Orthosis, Sagittal Control, with Rigid Anterior and Posterior Panels, Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0648	Lumbar-Sacral Orthosis, Sagittal Control, with Rigid Anterior and Posterior Panels, Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
L0633	Lumbar-Sacral Orthosis, Sagittal-Coronal Control, with Rigid Posterior Frame/Panel(S), Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Lateral Strength Provided by Rigid Lateral Frame/Panels, Produces Intracavitary Pressure to Reduce Load on Intervertebral Discs, Includes Straps, Closures, May Include Padding, Stays, Shoulder Straps, Pendulous Abdomen Design, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0649	Lumbar-Sacral Orthosis, Sagittal-Coronal Control, with Rigid Posterior Frame/Panel(S), Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Lateral Strength Provided by Rigid Lateral Frame/Panels, Produces Intracavitary Pressure to Reduce Load on Intervertebral Discs, Includes Straps, Closures, May Include Padding, Stays, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
L0637	Lumbar-Sacral Orthosis, Sagittal-Coronal Control, with Rigid Anterior and Posterior Frame/Panels, Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Lateral Strength Provided by Rigid Lateral Frame/Panels, Produces Intracavitary Pressure to Reduce Load on Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0650	Lumbar-Sacral Orthosis, Sagittal-Coronal Control, with Rigid Anterior and Posterior Frame/Panels, Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Lateral Strength Provided by Rigid Lateral Frame/Panels, Produces Intracavitary Pressure to Reduce Load on Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf
L0639	Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Anterior Extends from Symphysis Pubis to Xyphoid, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Overall Strength is Provided by Overlapping Rigid Material and Stabilizing Closures, Includes Straps, Closures, May Include Soft Interface, Pendulous Abdomen Design, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L0651	Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra, Anterior Extends from Symphysis Pubis to Xyphoid, Produces Intracavitary Pressure to Reduce Load on the Intervertebral Discs, Overall Strength is Provided by Overlapping Rigid Material and Stabilizing Closures, Includes Straps, Closures, May Include Soft Interface, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf

RETIRED

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
L1600	Hip Orthosis, Abduction Control Of Hip Joints, Flexible, Frejka Type with Cover, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise		No Corresponding Code
L1610	Hip Orthosis, Abduction Control Of Hip Joints, Flexible, (Frejka Cover Only), Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise		No Corresponding Code
L1620	Hip Orthosis, Abduction Control Of Hip Joints, Flexible, (Pavlik Harness), Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise		No Corresponding Code
L1810	Knee Orthosis, Elastic with Joints, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L1812	Knee Orthosis, Elastic with Joints, Prefabricated, Off-The-Shelf
L1832	Knee Orthosis, Adjustable Knee Joints (Unicentric or Polycentric), Positional Orthosis, Rigid Support, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L1833	Knee Orthosis, Adjustable Knee Joints (Unicentric or Polycentric), Positional Orthosis, Rigid Support, Prefabricated, Off-The Shelf
L1843	Knee Orthosis, 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 Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	K0901	Knee Orthosis, 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
L1845	Knee Orthosis, 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 Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	K0902	Knee Orthosis, 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

RETIRED

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
L1847	Knee Orthosis, Double Upright with Adjustable Joint, with Inflatable Air Support Chamber(S), Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L1848	Knee Orthosis, Double Upright with Adjustable Joint, with Inflatable Air Support Chamber(S), Prefabricated, Off-The-Shelf
L3677	Shoulder Orthosis, Shoulder Joint Design, Without Joints, May Include Soft Interface, Straps, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L3678	Shoulder Orthosis, Shoulder Joint Design, Without Joints, May Include Soft Interface, Straps, Prefabricated, Off-The-Shelf
L3807	Wrist Hand Finger Orthosis, Without Joint(S), Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L3809	Wrist Hand Finger Orthosis, Without Joint(S), Prefabricated, Off-The-Shelf, Any Type
L3915	Wrist Hand Orthosis, Includes One or More Nontorsion Joint(S), Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L3916	Wrist Hand Orthosis, Includes One or More Nontorsion Joint(S), Elastic Bands, Turnbuckles, May Include Soft Interface, Straps, Prefabricated, Off-The-Shelf
L3917	Hand Orthosis, Metacarpal Fracture Orthosis, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L3918	Hand Orthosis, Metacarpal Fracture Orthosis, Prefabricated, Off-The-Shelf
L3923	Hand Finger Orthosis, Without Joints, May Include Soft Interface, Straps, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L3924	Hand Finger Orthosis, Without Joints, May Include Soft Interface, Straps, Prefabricated, Off-The-Shelf
L3929	Hand Finger Orthosis, Includes One or More Nontorsion Joint(S), Turnbuckles, Elastic Bands/Springs, May Include Soft Interface Material, Straps, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L3930	Hand Finger Orthosis, Includes One or More Nontorsion Joint(S), Turnbuckles, Elastic Bands/Springs, May Include Soft Interface Material, Straps, Prefabricated, Off-The-Shelf
L4360	Walking Boot, Pneumatic And/Or Vacuum, with or Without Joints, with or Without Interface Material, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L4361	Walking Boot, Pneumatic And/Or Vacuum, with or Without Joints, with or Without Interface Material, Prefabricated, Off-The-Shelf

RETIRED

ORTHOTICS AND PROSTHETICS

HCPCS	Custom Fitted Codes	HCPCS	Off-The-Shelf Codes
L4386	Walking Boot, Non-Pneumatic, with or Without Joints, with or Without Interface Material, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L4387	Walking Boot, Non-Pneumatic, with or Without Joints, with or Without Interface Material, Prefabricated, Off-The-Shelf
L4396	Static or Dynamic Ankle Foot Orthosis, Including Soft Interface Material, Adjustable For Fit, For Positioning, May Be Used For Minimal Ambulation, Prefabricated Item that has been Trimmed, Bent, Molded, Assembled, or Otherwise Customized to Fit a Specific Patient by an Individual with Expertise	L4397	Static or Dynamic Ankle Foot Orthosis, Including Soft Interface Material, Adjustable For Fit, For Positioning, May Be Used For Minimal Ambulation, Prefabricated, Off-The-Shelf

OVERPAYMENTS AND REFUNDS

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

OXYGEN

Oxygen 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 October 2014 through January 2015 are as follows:

The E0439 review involved 199 claims, of which 134 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 68%.

The E0434 review involved 101 claims, of which 72 were denied. Based on dollars, this resulted in an overall potential improper payment rate of 54%.

View top denial reasons and educational resources on the Medical Review page.

RETIRED

OXYGEN

Oxygen and Oxygen Equipment (HCPCS E1390) Notification of Service Specific Prepayment Targeted Review

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

E1390: OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE

Service specific targeted reviews are initiated to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis. This review is being initiated based on a high Comprehensive Error Rate Testing (CERT) error rate.

See the complete notification under Medical Review.

PARENTERAL/ENTERAL NUTRITION

Enteral and Parenteral Nutrition DIF Instruction Clarification

Per the article titled "DME Information Forms (DIFs) Usage for Enteral and Parenteral Nutrition and External Infusion Pumps" a recertification DIF is required to be submitted when the length of need (LON) previously entered on an Enteral or Parenteral Nutrition DIF has expired and the ordering physician is extending the LON. The recertification date should match the order date by the physician and would need to be prior to the end of the previous LON. Chapter 4 of the Noridian Supplier Manual has been updated to reflect the need for the recertification DIF.

In the case of the LON changing as well as elements of the DIF also changing (calories, days per week, etc.), those normally requiring a revised DIF, a recertification DIF would be the required.

Resources:

- DIFs Usage for Enteral and Parenteral Nutrition and External Infusion Pumps

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

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from September 2014 through December 2014 are as follows:

The B4150 review currently has an overall potential improper payment rate of 63% and the B4154 review currently has an overall potential improper payment rate of 47%.

For complete details, see Enteral Nutrition (HCPCS B4150, B4154) Quarterly Results of Service Specific Prepayment Review.

Parenteral Nutrtion (HCPCS B4185, B4197) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D DME MAC Medical Review Department is conducting a service specific review of HCPCS codes B4185 and B4197. The quarterly edit effectiveness results from October 2014 through January 2015 are as follows:

The B4185 review involved 45 claims, of which 40 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **91%**.

The B4197 review involved 28 claims, of which 25 were denied. Based on dollars, this resulted in an overall potential improper payment rate of **82%**.

View top denial reasons and educational tools on the Medical Review page.

RETIRED

PRESSURE REDUCING SUPPORT SURFACES

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

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0181 and E0185. The quarterly edit effectiveness results from November 2014 through January 2015 are as follows:

The E0181 review involved 139 claims, of which 109 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **63%**.

The E0185 review involved 214 claims, of which 143 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of **72%**.

View top denial reasons and educational resources on the Medical Review page.

Group 2 Pressure Reducing Support Surfaces (HCPCS E0277) Quarterly Results of Service Specific Prepayment Review

The Jurisdiction D, DME MAC, Medical Review Department is conducting a service specific review of HCPCS code(s) E0277. The quarterly edit effectiveness results from November 2014 through January 2015 are as follows:

The E0277 review involved 106 claims, of which 57 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 56%.

View top denial reasons and educational resources on the Medical Review page.

REIMBURSEMENT

ASP Medicare Part B Drug Pricing Files and Revisions - July 2015 Quarterly

MLN Matters® Number: MM9159
Related Change Request (CR) #: CR 9159
Related CR Release Date: May 15, 2015
Effective Date: July 1, 2015
Related CR Transmittal #: R3258CP
Implementation Date: 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) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9159 which instructs MACs to download and implement the July 2015 Average Sales Price (ASP) drug pricing files and, if released by CMS, the April 2015, January 2015, October 2014, and July 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 July 6, 2015, with dates of service July 1, 2015, through September 30, 2015. MACs will not search and adjust claims that have already been processed unless brought to their attention. Make sure 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.

RETIRED

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).

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

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

The absence or presence of a 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, CR9159 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3258CP.pdf on the CMS website.

DMEPOS Fee Schedule – July 2015 Quarterly Update

MLN Matters® Number: MM9177
Related Change Request (CR) #: CR 9177
Related CR Release Date: May 15, 2015
Effective Date: January 1, 2015 - for implementation of fee schedule amounts for codes in effect on January 1, 2015; July 1, 2015 for all other changes
Related CR Transmittal #: R3257CP
Implementation Date: July 6, 2015

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

This article is based on Change Request (CR) 9177 which advises providers of the July 2015 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 staff is aware of these updates.

Background

The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The quarterly update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf on the CMS website.

RETIRED

Section 1834 (a), (h), and (i) of the Social Security Act requires payment on a fee schedule basis for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Key Points

Specific Coding and Pricing Issues

1. As part of this update, fees are established for Healthcare Common Procedure Coding System (HCPCS) code A4602, which was added to the HCPCS file effective January 1, 2015. This item has been paid on a local fee schedule basis prior to this update. **Claims for code A4602 that have already been processed and have dates of service on or after January 1, 2015, may not be adjusted to reflect newly established fees.**
2. Section 203 of the Achieving a Better Life Experience (ABLE) Act of 2014 amended Section 1834(a)(1) of the Social Security Act to exclude Medicare coverage for vacuum erection systems.
3. As of July 1, 2015, HCPCS codes describing vacuum erection systems are statutorily excluded from Medicare coverage and are not payable when billed to Medicare. The fee schedules for the following vacuum erection system HCPCS codes will be removed from the DMEPOS fee schedule file effective July 1, 2015:
   a. L7900 Male vacuum erection system; and
   b. L7902 Tension ring, for vacuum erection device, any type, replacement only, each

Effective for claims with dates of service on or after July 1, 2015, claims submitted with HCPCS codes L7900 and L7902 will be denied using the following codes:

- Group Code -PR – "Patient Responsibility."
- Claim Adjustment Reason Codes (CARC) 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.
- Remittance Advice Remark Code (RARC) N425 – "Statutorily excluded service(s)".

Also, note that MACs will follow existing procedures for denying statutorily non-covered items, when these codes are billed with the "GY" modifier.

4. As part of the January 2015 update, fee schedules for HCPCS code A7048 (Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each) were added to the DMEPOS fee schedule file. In response to questions received on these fee schedule amounts, CMS is providing the following clarification:
   a. HCPCS code A7048 describes all supplies, including the appropriately sized collection container, that are needed for a collection unit change when draining an implanted catheter.
   b. A7048 is used for each single, complete collection and represents a supply allowance rather than a specifically defined kit.
   c. Items included in this code are not limited to pre-packaged kits that are bundled by manufacturers or distributors.
   d. The A7048 supplies include, but are not limited to, drainage tubing, gauze, dressings and any number of collection units of various sizes needed to capture the drainage for each complete drainage collection.
   e. Since included in A7048, supplies that are used in a collection change should not be separately billed using miscellaneous codes.

Additional Information

The official instruction, CR 9177, issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3257CP.pdf on the CMS website.

You may want to review the related MLN Matters® Article, SE1511 (Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014).

RETIRED

Section 504: Implement National MSNs in Alternate Formats

MLN Matters® Number: MM9153
Related Change Request (CR) #: CR 9153
Related CR Release Date: May 8, 2015
Effective Date: October 1, 2015
Related CR Transmittal #: R1499OTN
Implementation Date: October 5, 2015

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9153 alerts providers that the Centers for Medicare & Medicaid Services (CMS) has designated the MACs as responsible for printing requests for large print Medicare Summary Notices (MSNs) that are sent to beneficiaries in alternate formats, and to have a third party contractor responsible for requests for Braille, CD-ROM, and Audio alternate formats. MACs are required to produce large print MSNs for beneficiaries in their respective jurisdictions who prefer large print MSNs.

Background

CMS has an obligation to provide the MSN in alternate formats for beneficiaries who elect one of the formats as a preference. CMS has been working on the alternate format project for several years. Most recently, CMS has directed MACs to provide MSNs to a subset of beneficiaries through a manual process. CR9153 implements the MAC requirements to produce large print MSNs for beneficiaries with that preference in their respective jurisdictions.

Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794 forbids Executive Agencies and recipients of Federal financial assistance from excluding individuals with disabilities or denying them an equal opportunity to receive program benefits and services.

Additional Information

The official instruction, CR9153 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1499OTN.pdf on the CMS website.

Update to RARC, CARC, MREP and PC Print – Revised

MLN Matters® Number: MM9125 Revised
Related Change Request (CR) #: CR 9125
Related CR Release Date: April 27, 2015
Effective Date: July 1, 2015
Related CR Transmittal #:R3242CP
Implementation Date: July 6, 2015

This article was revised on April 27, 2015, to reflect an updated Change Request (CR). That CR, made changes to the Attachments I and II with regard to new and deactivated codes (pages 4-5 below). All other information remains the same.

RETIRED

Provider Types Affected

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

Provider Action Needed

This article is based on CR9125, which updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and 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, which 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 Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR9125, 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.

CR9125 lists only the changes that have been approved since the last code update CR (CR9004 issued on January 9, 2015, with a related MLN Matters® article available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9004.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.

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.

This recurring Code Update CR lists only the changes approved since the last recurring Code Update CR once. If any modification or deactivation becomes effective at a future date, MACs must make sure that they update on the effective date or the quarterly release date that matches the effective date as posted on the WPC website.

Changes in CARC List Since CR 9004

The following tables are changes in the CARC database since the last code update in CR 9004.

RETIRED

New Codes – CARC

Code	Modified Narrative	Effective Date
269	Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	03/01/2015

Modified Codes – CARC

Code	Modified Narrative	Effective Date
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: this must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	03/01/2015
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	03/01/2015
133	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).	03/01/2015
267	Claim/service spans multiple months. Rebill as separate claim/service. This change effective 9/1/2015: Claim/service spans multiple months. 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.)	04/01/2015

Deactivated Codes – CARC

Code	Current Narrative	Effective Date
A7	Presumptive Payment Adjustment	07/01/2015

Changes in RARC List Since CR 9004

The following tables are changes in the RARC database since the last code update in CR 9004.

New Codes – RARC

Code	Modified Narrative	Effective Date
N736	Incomplete/invalid Sleep Study Report.	03/01/2015
N737	Missing Sleep Study Report.	03/01/2015
N738	Incomplete/invalid Vein Study Report.	03/01/2015
N739	Missing Vein Study Report.	03/01/2015
N740	The member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service.	03/01/2015
N741	This is a site neutral payment.	03/01/2015

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Code	Modified Narrative	Effective Date
N742	Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html on the CMS website.	03/01/2015
N743	Adjusted because the services may be related to an employment accident.	03/01/2015
N744	Adjusted because the services may be related to an auto accident.	03/01/2015
N745	Missing Ambulance Report.	03/01/2015
N746	Incomplete/invalid Ambulance Report.	03/01/2015
N747	This is a misdirected claim/service. Submit the claim to the payer/plan where the patient resides.	03/01/2015
N748	Adjusted because the related hospital charges have not been received.	03/01/2015
N749	Missing Blood Gas Report.	03/01/2015
N750	Incomplete/ invalid Blood Gas Report.	03/01/2015
N751	Adjusted because the drug is covered under a Medicare Part D plan.	03/01/2015
N752	Missing/incomplete/invalid HIPPS Treatment Authorization Code (TAC).	03/01/2015

Modified Codes – RARC

Code	Modified Narrative	Effective Date
N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	03/01/2015

Deactivated Codes – RARC

Code	Current Narrative	Effective Date
N483	Missing Periodontal Charts	05/01/2015
N484	Incomplete/invalid Periodontal Charts.	05/01/2015
N29	Missing documentation/orders/notes/summary/report/chart	03/01/2016
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart	03/01/2016

The full CARC and RARC lists must be downloaded from the WPC website available at http://wpc-edi.com/Reference on the Internet.

Additional Information

The official instruction, CR 9125, issued to your MAC regarding this change, is available at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3242CP.pdf on the CMS website.

Correct Coding – Urinary "No-Touch" Catheters

DME MAC Joint Publication

Urinary "no-touch" catheter systems are designed to perform urinary catheterization without the need to directly touch the catheter during insertion. The Urologic Supplies Local Coverage Determination (LCD) provides coverage for these products as either a single-use intermittent catheter (A4351, A4352) or as a sterile kit (A4353) depending upon the configuration of the specific product. The narratives for these HCPCS codes are:

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A4351 - INTERMITTENT URINARY CATHETER; STRAIGHT TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMER, OR HYDROPHILIC, ETC.), EACH

A4352 - INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH

A4353 - INTERMITTENT URINARY CATHETER, WITH INSERTION SUPPLIES

In order to be correctly coded as A4353 the no-touch catheter must meet all of the requirements specified in the CODING GUIDELINES section of the Urologic Supplies related Policy Article. The guideline for A4353 says:

An intermittent urinary catheter with insertion supplies (A4353) is a kit, which includes a catheter and all supplies necessary for a single, sterile insertion (see below). Code A4353 may be used if any of the following 1, 2, or 3 is supplied:

1. A single sterile package containing both an intermittent urinary catheter and all necessary insertion/collection supplies: or
2. A sterile intermittent urinary catheter plus a separately-packaged sterile kit containing all necessary insertion/collection supplies; or,
3. **A sterile "no-touch" type of catheter system.**

The insertion kit (A4353) described in #1 and #2 above contains an intermittent urinary catheter (packaged separately from the other components in #2), lubricant, gloves, antiseptic solution, applicators, a drape, and a collection tray/bag in a sterile package intended for single use. The collection tray/bag is a separate item included within the kit; therefore, materials that serve as non-sterile packaging to contain all of the items in the kit do not meet this requirement. Except as noted in #2 above, code A4353 must not be billed if individual insertion kit components are provided as separate items. When providing a sterile kit, all components are included and packaged as a kit. Separate billing of individual components is considered as unbundling.

The product described in #3 is a single-catheter system that is functionally equivalent to a complete sterile insertion kit (A4353) containing a catheter and the additional components as described in the previous paragraph. In order to be coded as A4353, a "no-touch" type of catheter system must be a sterile, all-inclusive, self-contained system capable of accomplishing intermittent catheterization with sterile technique without the use of additional supplies such as gloves, lubricant, collection chamber, etc. Additional individual components must not be separately billed. Separate billing of additional supply items is considered as unbundling. (Emphasis added)

Only those "no-touch" systems that are the complete functional equivalent of a standard sterile kit, including the presence of a collection chamber, are eligible to be coded as A4353. The collection chamber may be an integral part of the catheter or may be a separate item provided as part of the complete system. Systems that do not have a collection chamber or otherwise are not functionally equivalent in performing a sterile-technique catheter insertion must be coded as an intermittent catheter, A4351 or A4352, depending upon the catheter configuration.

Refer to the Urologic Supplies LCD and related Policy Article for additional information about coverage, documentation and coding.

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

Urological Supplies (HCPCS A4351, A4353, A4357 and A4358) Results of Service Specific Prepayment Probe Review

The Jurisdiction D, DME MAC, Medical Review Department completed a widespread prepayment probe review of HCPCS code(s) A4351, A4353, A4357 and A4358. This review was initiated based on the results of Comprehensive Error Rate Testing (CERT) analysis.

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UROLOGICAL SUPPLIES

The A4351 review involved 104 claims, of which 67 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 53%.

The A4353 review involved 72 claims, of which 55 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 75%.

The A4357 review involved 92 claims, of which 79 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 91%.

The A4358 review involved 110 claims, of which 93 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 78%.

View top denial reasons and educational resources on the Medical Review page.

VACUUM ERECTION DEVICES

Vacuum Erection Devices (HCPCS L7900) Quarterly Results of Service Specific Prepayment Review

The quarterly edit effectiveness results from the Jurisdiction D Medical Review Department from December 2014 through February 2015 are as follows:

The L7900 review currently has an overall potential improper payment rate of 94%.

For complete details, see Vacuum Erection Devices (HCPCS L7900) Quarterly Results of Service Specific Prepayment Review.

Vacuum Erection Devices – Non-Covered by Medicare

Joint DME MAC Publication

The Achieving a Better Life Experience (ABLE) Act of 2014 eliminated Medicare coverage for vacuum erection devices (VED). Consequently, claims billed to Medicare for codes L7900 and L7902 for dates of service on or after July 1, 2015 will be denied as non-covered (no benefit).

The DME MAC VED Local Coverage Determination and Related Policy Article will be revised to reflect this change in coverage, effective for dates of service on or after July 1, 2015.

VENTILATORS

Accreditation for Ventilators

MLN Matters® Number: SE1513

Provider Types Affected

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

Provider Action Needed

This article alerts providers that all items in the ventilator policy group at: https://www.dmepdac.com/resources/reports.html are included in the DME frequent and substantial servicing payment classification for items requiring frequent and substantial servicing, and should not be confused with Positive Airway Pressure (PAP) devices such as Continuous PAP devices or Bi-level PAP devices.

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The ventilator policy group includes ventilators used with both invasive and non-invasive interfaces which are classified by law as requiring frequent and substantial servicing in order to avoid risk to the patient's health. The Medicare monthly rental amount for these ventilators includes payment for the equipment and all related items and services necessary to ensure that the patient has access to equipment in good working order at all times. More information can be found at http://www.medicarenhic.com/viewdoc.aspx?id=2653 on the Internet.

If you are a supplier who furnishes or intends to furnish ventilators, you should contact a CMS-approved accreditation organization to ensure you meet all necessary accreditation requirements.

Background

Section 1834(a)(3) of the Social Security Act defines the items requiring frequent and substantial servicing and excludes PAP devices. PAP devices produce positive airway pressure used in the treatment of conditions specified in both National and Local Coverage Determinations, and are reimbursed as capped-rental items. These devices include both Continuous PAP devices and Bi-level PAP devices:

- HCPCS code E0601 - Continuous positive airway pressure (CPAP) device; and
- HCPCS 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); and
- HCPCS code 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)

To further distinguish ventilators from PAP devices, CMS is revising the descriptor language on the 855S application form for ventilators. This revision will also make clear that suppliers who furnish ventilators must meet all applicable requirements for accreditation such as ensuring that frequent and substantial servicing is provided so that the patient has access to functioning equipment at all times.

Key Points

Most suppliers who currently furnish products in the ventilator policy group to Medicare beneficiaries are already in compliance with the ventilator accreditation requirements and Appendix A of the DMEPOS Quality Standards at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/DMEPOS_Qual_Stand_Booklet_ICN905709.pdf on the CMS website.

The accreditation organizations will require all suppliers who furnish HCPCS codes in the ventilator policy group to meet accreditation requirements for items classified as frequent and substantial servicing, to ensure the beneficiary has access to functioning equipment at all times. Suppliers who submit claims with dates of service on or after October 1, 2015, must be in compliance with these accreditation requirements and Appendix A of the DMEPOS Quality Standards. After this date, Medicare suppliers furnishing products in the ventilator policy group that are not in compliance must stop furnishing these items to Medicare beneficiaries until these requirements are met.

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-Net work-MLN/MLNMattersArticles/index.html under - How Does It Work.

Ventilators (HCPCS E0464) Results of Service Specific Prepayment Probe Review

The Jurisdiction D, DME MAC, Medical Review Department completed a widespread prepayment probe review of HCPCS code E0464. This review was initiated based on data analysis that identified changes in billing patterns.

The E0464 review involved 103 claims, of which 59 were denied. Based on dollars, this resulted in an overall claim potential improper payment rate of 57%.

View top denial reasons and educational resources on the Medical Review page.

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